CAN MINORITY PROVIDERS SURVIVE HEALTH CARE REFORM?

HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS SUBCOMMITTEE

OF THE

COMMITTEE ON GOVERNMENT OPERATIONS

HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

AUGUST 5, 1994

Printed for the use of the Committee on Government Operations

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CAN MINORITY PROVIDERS SURVIVE HEALTH CARE REFORM?

FRIDAY, AUGUST 5, 1994

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HUMAN RESOURCES
AND INTERGOVERNMENTAL RELATIONS,
COMMITTEE ON GOVERNMENT OPERATIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:45 a.m., in room 2247, Rayburn House Office Building, Hon. Edolphus Towns (chairman of the subcommittee) presiding.

Present: Representatives Towns, Payne, Schiff, and Portman.

Also present: Representative Stokes.

Staff present: Brenda E. Pillors, professional staff member; Martine M. DiCroce, clerk; and Martha Morgan, minority professional staff member.

Mr. TOWNS. The Subcommittee on Human Resources and Intergovernmental Relations will come to order.

Today, we have a hearing on, "Can Minority Providers Survive Health Care Reform?" I would like to begin by welcoming all the witnesses this morning.

As you know, the health care delivery system in this country is in a crisis situation. We have over 37 million Americans with no health insurance and American workers who can no longer rely on job-related health benefits because their employers consider copayments to be too high.

Next week, my colleagues and I will be considering health care reform legislation based upon a managed competition model, which is dependent upon the use of managed care entities for the delivery of health services.

Amidst all this uncertainty, the participation of minority providers within a managed care setting is the most unstable. African-Americans only comprise some 3 percent of current physicians and dentists. Hispanic physicians have a larger representation, 5.4 percent, but are severely underrepresented in the dentistry, at only 2.9 percent.

Both groups have less than 10 percent representation in other health care professions, such as registered nurses, pharmacists, physical therapists, and dental assistants. There are no quotable statistics in any of these professions for Asians.

The only numbers available for Asians are 14 percent in medical school and only 3 percent of America's nursing students are Asians. These numbers show that without even considering those providers

working within a managed care system, the minority representation in health care is dangerously low.

Many of these providers service urban communities with high-risk patients. Because caring for these patients is more costly and reduces the profit margin, it is difficult for their providers to contract with HMO's.

Furthermore, minority physicians are not keeping up with the Dr. Joneses. They lack the experience of working within a managed care system. If the managed competition model moves forward under health care reform, providers will have no choice but to play catch up in a game that might not even want them as players or even allow them to pick up a uniform.

A couple of solutions to this dilemma are the formation of minority-owned HMO's and initiatives involving joint minority- and majority-owned company ventures and equity partnerships. Another solution is the education of medical students about managed care financing. The possibility of these solutions surviving health care reform is an issue that we will be addressing today. Showing a problem exists will not be productive without offering viable solutions.

Our success in improving health access for all Americans may depend on how well managed care systems can deliver health care services. The ability of minority providers to remain competitive within a managed care setting, however, is still a serious dilemma.

I look forward today to hearing from the witnesses about how we can identify the problem and correct it.

At this time, I would like to call to the witness table the Honorable Louis Stokes from Cleveland, OH, a person that I really can't say enough about in terms of his leadership on health care issues, one that we all look to and enjoy working with because of his commitment and dedication. And the little progress that we have made is basically because of the involvement of Congressman Stokes.

So I could go on and on talking about the kind of things that he has done and the leadership that he has provided, not only to the Congressional Black Caucus but to the Congress as a whole.

So Congressman Stokes, it is a pleasure to welcome you to this hearing and we look forward to your comments. You may proceed in any way you wish.

[The prepared statement of Hon. Edolphus Towns follows:]

ONE HUNDRED THIRD CONGRESS
Congress of the United States
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Human Resources and Intergovernmental Relations
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of the
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August 5, 1994

OPENING STATEMENT OF CHAIRMAN EDOLPHUS TOWNS
FOR THE HEARING:
CAN MINORITY PROVIDERS SURVIVE HEALTH CARE REFORM?

I want to welcome all of you here this morning and would like to thank the participants for taking time out of their busy schedules to be here to address the question, can minority providers survive health care reform?

As you know, the health care delivery system in this country is in a crisis situation. We have over 37 million Americans with no health insurance and American workers who can no longer rely on job-related health benefits because their employers consider co-payments to be too high. Next week, we will be considering health care reform legislation based upon a "managed competition model" which is dependent upon the use of managed care entities for the delivery of health services.

Amidst all this uncertainty, the participation of minority providers within a managed care setting is the most unstable. African-Americans only comprise some 3 percent of physicians and dentists. Hispanic physicians have a larger representation, 5.4 percent, but are severely under-represented in dentistry at only 2.9 percent. Both groups have less than 10 percent representation in other health care professions such as registered nurses, physical therapists, and dental assistants. There are no quotable statistics in any of these professions for Asians. The only numbers available for Asians are 14 percent in medical school and only 3 percent of America's nursing students are Asian. These numbers show that without even considering those providers working within a managed care system, the minority representation in health care is dangerously low.

Many of these providers service urban communities with high-risk patients. Because caring for these patients is more costly, it is difficult for their providers to contract with HMOs. Furthermore, minority physicians are not "keeping up with the Dr. Joneses." They lack the

--over--

experience of working within a managed care system that non-minorities have. If the managed competition model moves forward under health care reform, providers will have no choice but to play catch up in a game that might not even want them as players.

It is difficult for many providers to show outright discrimination on the part of HMOs due to their ability to drop provider contracts without justification. Last April, CIGNA HealthCare of Kansas/Missouri announced the termination of more than 500 physicians and nine major hospitals from its HMO plan. A disproportionate number of those terminated were minority providers. The only reason given for the termination was the "restructuring and re-alignment of their managed care system designed to improve services to its clients." Unfortunately this is not a unique case as several of our witnesses will affirm.

A couple of solutions to this dilemma are the formation of minority-owned HMOs, and initiatives involving joint minority- and majority- owned company ventures and equity partnerships. Another solution is the education of medical students about managed care financing. The possibility of these solutions surviving health care reform is an issue that we will be addressing today. Showing a problem exists will not be productive without offering viable solutions.

Our ability to improve health access for all Americans may depend on how well managed care systems can deliver health care services. The ability of minority providers to remain competitive within a managed care setting, however, is still a dilemma. I look forward to hearing from today's witnesses about how we can best assess this situation.

STATEMENT OF HON. LOUIS STOKES, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. STOKES. Thank you very much, Mr. Chairman, and members of the committee. Mr. Chairman, I very much appreciate your very generous and kind words. And let me just say that I could not have done what I have done without the close working relationship I have had with you and others in the Congressional Black Caucus, and particularly in your case, the strong leadership you have given in the area of health ever since coming into the Congress, and even before you got on this particular committee, where you now enjoy a position of being a subcommittee chairman.

So I want to also commend you for the outstanding work that you have done in this area also.

Mr. TOWNS. Thank you.

Mr. STOKES. Mr. Chairman and members of the subcommittee, as chairman of the Congressional Black Caucus Health Braintrust and as an advocate for quality health care for all Americans, I appreciate your convening this very special and important health care reform hearing to examine the impact of reform on minority providers. Health care reform is the most pressing issue facing our Nation today.

As the health care reform debate intensifies, this hearing affords the Congress the opportunity necessary to identify what is needed to ensure and to strengthen minority participation in the managed care industry, to examine the impact of industry consolidation on providers of color, to identify operating policies that facilitate and condone discrimination, exclusion and termination of minority providers within the health care industry, to identify solutions for correcting these problems, and more importantly, to determine the measures needed to prevent them.

In the wake of health care reform, with increasing industry buyouts and buy-ins, many of which condoned the exclusion of minority health care providers, we are forced to ask ourselves a very important and revealing question: Can minority health care providers successfully survive health care reform?

Mr. Chairman, the distinguished and diverse group of individuals and organizations who will be appearing before your subcommittee today will provide us with the answer to this question and the solution for insuring minorities fair and equitable participation in the health care enterprise. Over the years, many of these organizations have worked with the Congressional Black Caucus Health Braintrust, giving endlessly of their time and effort to improve the quality of life for minorities.

In fact, many of them are in the trenches daily providing quality health care services to underserved populations in rural and urban areas across the country. Their patient population includes the sickest of the sick and the poorest of the poor.

Mr. Chairman, while we may not know what the final health care reform legislation will look like, what we do know is that for the legislation to be effective in addressing the crisis in minority health, it is absolutely paramount that the measure provides for fair and equitable participation of minorities in the health care enterprise.

It is vital that we realize, as we sit here today, many majority population-owned HMO's are refusing to hire minority health care providers. When hired, many face limitations and controls on the extent to which they are allowed to practice.

As we sit here today, many minority health care providers are losing their practices. If allowed to continue, this situation will escalate the crisis in minority health.

Mr. Chairman and members of the subcommittee, as the crisis in minority health continues, the enacted health care reform legislation must include provisions to ensure minorities a level playing field, to strengthen historically black colleges and universities, to enhance the few remaining African-American hospitals, and to ensure the viability of existing and the establishment of new minority-owned HMO's. It must also ensure an adequate supply of a full cadre of minority health care professionals.

As the crisis in minority health continues, the enacted reform legislation must include provisions to ensure minority consumers and health care providers active involvement at all levels of the health care enterprise. The challenge I think is ours.

Mr. Chairman, again, I want to thank you for convening this very important hearing. I look forward today to hearing from the very distinguished panel of witnesses that will be coming before your subcommittee. And if I can take just a moment, I would like to just personally say how pleased I am that the very next panel that comes behind me will contain Dr. Louis Sullivan, the former Secretary of the Department of Health and Human Services, who has now resumed his former duties as president of Morehouse College of Medicine, one of this Nation's most distinguished medical schools, along with Dr. Reed Tuckson, the president of Charles R. Drew University of Medicine and Science, who is the vice president, Association of Minority Health Professions Schools, and he will be followed by a host of very distinguished panelists. And I think we are very fortunate to have these very distinguished panelists appear before us and give the kind of expert testimony that you will receive from them today.

And so, Mr. Chairman, with that, I will conclude my statement. Once again, I thank you very much for this opportunity to appear before you and your subcommittee.

[The prepared statement of Hon. Louis Stokes follows:]

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE, AS CHAIRMAN OF THE CONGRESSIONAL BLACK CAUCUS HEALTH BRAINTRUST AND AS AN ADVOCATE FOR QUALITY HEALTH CARE FOR ALL AMERICANS, I APPRECIATE YOUR CONVENING THIS VERY SPECIAL AND IMPORTANT HEALTH CARE REFORM HEARING TO EXAMINE THE IMPACT OF REFORM ON MINORITY PROVIDERS. HEALTH CARE REFORM IS THE MOST PRESSING ISSUE FACING OUR NATION TODAY.

AS THE HEALTH CARE REFORM DEBATE INTENSIFIES, THIS HEARING AFFORDS US THE OPPORTUNITY NECESSARY TO IDENTIFY WHAT IS NEEDED TO ENSURE AND TO STRENGTHEN MINORITY PARTICIPATION IN THE MANAGED CARE INDUSTRY; TO EXAMINE THE IMPACT OF INDUSTRY CONSOLIDATION ON PROVIDERS OF COLOR; TO IDENTIFY OPERATING POLICIES THAT FACILITATE AND CONDONE DISCRIMINATION, EXCLUSION AND TERMINATION

OF MINORITY PROVIDERS WITHIN THE HEALTH CARE INDUSTRY; TO IDENTIFY SOLUTIONS FOR CORRECTING THESE PROBLEMS; AND MORE IMPORTANTLY, TO DETERMINE THE MEASURES NEEDED TO PREVENT THEM.

IN THE WAKE OF HEALTH CARE REFORM, WITH INCREASING INDUSTRY BUY-OUTs AND BUY-INs, MANY OF WHICH CONDONE THE EXCLUSION OF MINORITY HEALTH CARE PROVIDERS, WE ARE FORCED TO ASK OURSELVES A VERY IMPORTANT AND REVEALING QUESTION -- CAN MINORITY HEALTH CARE PROVIDERS SUCCESSFULLY SURVIVE HEALTH CARE REFORM?

MR. CHAIRMAN, THE DISTINGUISHED AND DIVERSE GROUP OF INDIVIDUALS AND ORGANIZATIONS APPEARING BEFORE THE SUBCOMMITTEE TODAY WILL PROVIDE US WITH THE ANSWER TO THIS QUESTION, AND THE SOLUTION FOR ENSURING MINORITIES FAIR AND EQUITABLE PARTICIPATION IN THE HEALTH CARE ENTERPRISE. OVER THE YEARS, MANY OF THESE

ORGANIZATIONS HAVE WORKED WITH THE CONGRESSIONAL BLACK CAUCUS HEALTH BRAINTRUST, GIVING ENDLESSLY OF THEIR TIME AND EFFORT TO IMPROVE THE QUALITY OF LIFE FOR MINORITIES.

IN FACT, MANY OF THEM ARE IN THE TRENCHES DAILY PROVIDING QUALITY HEALTH CARE SERVICES TO UNDERSERVED POPULATIONS IN RURAL AND URBAN AREAS ACROSS THE COUNTRY. THEIR PATIENT POPULATION INCLUDES THE SICKEST OF THE SICK, AND THE POOREST OF THE POOR.

MR. CHAIRMAN, WHILE WE MAY NOT KNOW WHAT THE FINAL HEALTH CARE REFORM LEGISLATION WILL LOOK LIKE, WHAT WE DO KNOW IS THAT FOR THE LEGISLATION TO BE EFFECTIVE IN ADDRESSING THE CRISIS IN MINORITY HEALTH, IT IS ABSOLUTELY PARAMOUNT THAT THE MEASURE PROVIDES FOR FAIR AND EQUITABLE PARTICIPATION OF MINORITIES IN THE HEALTH CARE ENTERPRISE.

IT IS VITAL THAT WE REALIZE, AS WE SIT HERE TODAY, MANY MAJORITY POPULATION-OWNED HMOs ARE REFUSING TO HIRE MINORITY HEALTH CARE PROVIDERS. WHEN HIRED, MANY FACE LIMITATIONS AND CONTROLS ON THE EXTENT TO WHICH THEY ARE ALLOWED TO PRACTICE. AS WE SIT HERE TODAY, MANY MINORITY HEALTH CARE PROVIDERS ARE LOSING THEIR PRACTICE. IF ALLOWED TO CONTINUE, THIS SITUATION WILL ESCALATE THE CRISIS IN MINORITY HEALTH.

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE, AS THE CRISIS IN MINORITY HEALTH CONTINUES, THE ENACTED HEALTH CARE REFORM LEGISLATION MUST INCLUDE PROVISIONS TO ENSURE MINORITIES A LEVEL PLAYING FIELD, TO STRENGTHEN HISTORICALLY BLACK COLLEGES AND UNIVERSITIES, TO ENHANCE THE FEW REMAINING AFRICAN AMERICAN HOSPITALS, AND TO ENSURE THE VIABILITY OF EXISTING AND THE

ESTABLISHMENT OF NEW MINORITY-OWNED HMOs. IT MUST ALSO ENSURE AN ADEQUATE SUPPLY OF A FULL CADRE OF MINORITY HEALTH CARE PROFESSIONALS.

AS THE CRISIS IN MINORITY HEALTH CONTINUES, THE ENACTED REFORM LEGISLATION MUST INCLUDE PROVISIONS TO ENSURE MINORITY CONSUMERS AND HEALTH CARE PROVIDERS ACTIVE INVOLVEMENT AT ALL LEVELS OF THE HEALTH CARE ENTERPRISE. THE CHALLENGE IS OURS.

MR. CHAIRMAN, AGAIN, I THANK YOU FOR CONVENING THIS VERY IMPORTANT HEARING. I LOOK FORWARD TO HEARING FROM OUR DISTINGUISHED PANEL OF WITNESSES.

Mr. TOWNS. Let me thank you again for your statement and to invite you to join us here as we listen to the witnesses, because I know what your schedule is like, but the point is if you can, I certainly would appreciate that.

But before you go, let me—either way, let me just sort of ask you a couple things. You know, as I listened to what you were saying, what you talked about in terms of how minorities could be shut out, and of course when we look at the fact that there is also the push in terms of primary care as well, and that we recognize the fact that before we start out, we are behind in terms of the amount of doctors that we have, in terms of 3 percent, and of course you can go on—you know the statistics as well as I do—what can we do at this point in time?

As you know, they are putting the paper together for this bill as we speak. What do you think we could do that might be able to sort of at least address some of these issues as we move forward?

Mr. STOKES. Thank you, Mr. Chairman.

First, let me say that I will be pleased to accept your invitation to join you in the hearings here this morning, and I have set aside some time to be able to be here because of the importance of this issue.

On the second part of your question, let me say that what we have tried to do through the Congressional Black Caucus Health Braintrust is to meet with the majority leader, Mr. Gephardt, and we have provided them with the document that we prepared on behalf of the minority community in terms of health care reform, and we have been now holding meetings with them.

The purpose of which is to try to get into the leadership bill those kind of provisions that will address these types of concerns that we are here talking about this morning. And toward that end, we have met with the majority leader. We have met with his staff, and we are participating again in a meeting with him tomorrow, all of which is aimed toward the inclusion of these kinds of provisions.

Let me say, just 2 days ago, Dr. Sullivan came to me on behalf of the Association of Minority Health Professions Schools and provided me with some proposed amendments that will address some of these kinds of problems. We have submitted those to the leadership and asked that they be included in the leadership plan.

Along with it, some of the other groups that have been working with us have given us some additional amendments, which we are proposing, and this is so important because I just left a breakout meeting that I was put on by the House leadership and I guess they have done this not with just me, but each of us have been assigned to special working groups. And the documents they handed out this morning, one of the documents was entitled the "House Democratic Health Reform Proposal," with one page descriptions. And there is a page in there entitled, "Continuing the Role of Managed Care," and on there they talk about employers who offer a managed care plan, managed care option under Medicare part C, funding the development of managed care, providing patient protections, and interestingly enough on this single page analysis of what appears in the proposed legislation with reference to managed care, there is not a single provision there relative to any type

of antidiscrimination clauses. And, of course, that is one of the areas that we feel we could be very helpful to leadership in providing antidiscrimination provisions.

Mr. TOWNS. You know, I am happy to hear that because as I listen and I talk to many minority physicians, they are concerned about the fact that this will, in some instances, put them out of business. You know, these are doctors in neighborhoods that they have been there struggling for years providing health care, and now all of a sudden, they are threatened. And I think that we need to be extremely concerned about that, because they were there, have been there providing services, and of course many of them have never had any difficulty, any kind of problems in malpractice, anything like that, but now all of a sudden that the rules of the game—actually the whole game is being changed and that they are now going to be left out. And, of course, I am hearing from that group on a daily basis.

So, I think that you are right in terms of whatever we do, that we cannot leave folks like that out, and I am happy to know in terms of your concerns and your involvement there as well.

Mr. STOKES. Thank you, Mr. Chairman.

I agree totally with you. I had occasion about a week ago to appear at the National Medical Association annual convention in Orlando, FL, and during the course of my appearance there, that was one of the major concerns expressed to me, for me to convey back to the members of the Congressional Black Caucus, and in particular, our health braintrust, these type of concerns. And, of course, they were the ones urging that at any such hearing of this sort, that you might conduct, that they would like the opportunity to appear here to be able to give you a firsthand view of what it is like for them having been in the trenches all these years when there was no health care reform, and now when health care reform, that they are brushed to the side, put in the background, and in many cases, put out of business as the big corporations move in to take advantage of the money being provided by the Federal Government through health care reform.

So, I think all of this makes your hearing this morning extremely important.

Mr. TOWNS. Right. Thank you.

Before we move on, we have been joined by the ranking member of the committee, Congressman Schiff, so I would like to yield to him at this time for any opening statements or comments or questions that he might have.

Mr. SCHIFF. First, I apologize for being a little bit late.

As you know, Mr. Chairman, and as our witnesses know, a lot is happening right now and there are some conflicts in the schedule. I just want to say I appreciate your holding this hearing.

I very much want to welcome our colleague, Congressman Stokes, for testifying, and I yield back.

Mr. TOWNS. Thank you very much.

I would also like to recognize Congressman Portman for any comments that he might have or questions at this time.

Mr. PORTMAN. Thank you, Mr. Chairman.

I want to thank you for having this hearing and welcome my colleague from Ohio, Mr. Stokes.

Mr. STOKES. Thank you.

Mr. PORTMAN. Thank you for being here. I wish I had heard your whole testimony. I will read it. I appreciate some of these concerns being raised.

As you know, Mr. Chairman, I represent several rural counties that actually have some similar issues. I see some parallel concerns and I look forward to the testimony of Dr. Sullivan and others.

Thank you, Mr. Chairman.

Mr. TOWNS. Thank you very much. At this time, I would like to ask Congressman Stokes to join us.

Mr. STOKES. Thank you very much, Mr. Chairman. I would like to do that.

Mr. TOWNS. Thank you. Thank you very much.

At this time, I would like to call our second panel, the Honorable Louis Sullivan, former Secretary of the Department of Health and Human Services, now president of Morehouse College of Medicine; Dr. Reed V. Tuckson, president of Charles R. Drew University of Medicine and Science and vice president of Association of Minority Health Professions Schools.

Let me welcome both of you here, and of course you have 5 minutes to summarize, which will allow the members of the panel an opportunity to raise additional questions with you.

So, Dr. Sullivan, why don't you begin.

STATEMENTS OF LOUIS SULLIVAN, M.D., FORMER SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, PRESIDENT, MOREHOUSE COLLEGE OF MEDICINE; AND REED V. TUCKSON, M.D., PRESIDENT, CHARLES R. DREW UNIVERSITY OF MEDICINE AND SCIENCE, VICE PRESIDENT, ASSOCIATION OF MINORITY HEALTH PROFESSIONS SCHOOLS

Dr. SULLIVAN. Thank you very much, Mr. Chairman.

Mr. TOWNS. Glad to see you.

Dr. SULLIVAN. Thank you very much, Mr. Chairman, it is a pleasure to be here also, with Congressmen Schiff, Portman, and Stokes.

We are very pleased to have this opportunity to appear before you with my esteemed colleague, Dr. Reed Tuckson, president of the Drew University College of Medicine and Sciences and vice president of the Association of Minority Health Professions Schools. Of course, the Morehouse School of Medicine is a member of that association.

Let me begin, Mr. Chairman, by commending you for your leadership, as well as that of the subcommittee. Your vision and your courage in speaking for the voices of those in our country who are often ignored or forgotten, we commend you for that.

Mr. Chairman, in conjunction with Representatives Louis Stokes, John Lewis, Kweisi Mfume and other Members of the Congressional Black Caucus, you have been stalwart, vigorous advocates for our poor and minority communities, people who have been underserved by our health care system.

We are witnessing a devastating health problem in our Nation's minority communities, problems that need direct, targeted actions to address the disproportionate rates of disease, disability, and

death. So I thank you for holding these hearings to highlight the complex, multifaceted needs of our poor and minority citizens.

These problems must be addressed simultaneously on a broad front. Several actions are required. For instance, greater investment in preventive services, reduced paperwork through administrative reforms in our system, broader insurance coverage, and malpractice reform is also needed to help our poor and minority citizens. These actions are essential for improving minority health status.

But by themselves, these changes will not be enough. As Dr. Tuckson will point out in his testimony, the values conveyed by our minority institutions are vital to influencing the health status of our citizens. Fully inclusive, racially sensitive, culturally sensitive hospitals, clinics and other health care settings are crucial for improved health status in our minority communities.

We need to make the health care system cognizant of the needs of minority citizens, and we have to build a greater openness and trust into that system. Otherwise, administrative reform and changes in reimbursement will have little impact on those who do not feel welcome in the system, or those who have no access to facilities or to health personnel.

Unfortunately, our health system is far from representative. For example, while only—while over 12 percent of the Nation's population is African-American, blacks are less than 8 percent of the Nation's first year medical students. They are less than 6 percent of medical school graduates, and they are less than 4 percent of medical school faculty members.

We must also recognize that our minority communities have been excluded from the health care enterprise in other ways. There are a variety of factors that tell minorities, you are not welcome. Reimbursement for services often does not cover the true cost for caring for many minority and poor citizens, providing market incentives to first treat anyone but minorities and the poor.

Surrogate measures of quality, such as the 50/50 rule in Medicare HMO's, often work to the detriment of our minority citizens. When discriminated against in forming health care systems, minority physicians do not have the clearly defined right to sue.

Few health plans are minority owned, largely due to a lack of access to capital. Add it up, and the disincentives are staggering, constituting a barrier to care that is covertly keeping large numbers of our most needy citizens from getting adequate and appropriate care.

One answer is to increase the number of physicians who are minorities. There is no adequate substitute for more black, Hispanic, native American, and Asian-American physicians. We must work to attract and train more minority nurses, physician assistants, and other members of the health care team. This requires more substantial investment in our Nation's four historically black medical schools, including funding for infrastructure, for education, for outreach efforts, for policy studies, and for biomedical research.

We also need a substantial and sustained proliferation of primary care providers. According to the Council on Graduate Medical Education, by the year 2000, more than half of our Nation's physicians should be primary care providers for the optimal delivery of

appropriate health care. But that means that the Nation's current training rate for primary care physicians must more than double.

Let me add that this deficiency would be much worse without the contributions of the Nation's four predominantly black medical schools. For example, last year, the Association of American Medical Colleges reported that the Morehouse School of Medicine is the No. 1 school in the Nation in the percentage of our graduates who are practicing as primary care physicians. This compares to 15 percent of graduating medical school seniors choosing primary care fields for their careers today.

Mr. Chairman, we must foster creative solutions that take health personnel beyond the four walls of their offices or their clinics. We need to place health personnel in housing projects, in schools, in underserved rural settings, and in other places that make health services readily accessible. We need to make the health care system more dynamic, more responsive, more accessible through imaginative, realistic, and innovative actions.

But I am very concerned that increasing standardization of health services may exclude the particular needs of minority patients. One safeguard would be to recognize that not all health institutions serve the same populations. Facilities operating in medically distressed areas should be given more resources, rather than being fiscally squeezed. We need to expand our urban and rural outreach efforts, not eliminate them by funding all health settings by the same formula.

Finally, Mr. Chairman, we need to make our health system more representative, more just, and more equitable by removing the disincentives for physicians, administrators, and owners of the health plans.

And I am submitting for the record a list of detailed actions that would help to ensure equitable opportunities for minority health care providers.

Mr. TOWNS. Without objection, it will be included.

[The prepared statement of Mr. Sullivan follows:]

Thank you, Mr. Chairman. I commend you and the subcommittee for your leadership, vision and courage in speaking for the voices in our country that are often ignored or forgotten.

Mr. Chairman, in conjunction with Representatives Louis Stokes, John Lewis, Kweisi Mfume and other members of the Congressional Black Caucus, you have been stalwart, vigorous advocates for our poor and minority citizens -- people who have been underserved by our health care system. We are witnessing a devastating health crisis in our minority communities, and only direct, targeted action will address the disproportionate rates of disease, disability and death. I thank you for holding these hearings to highlight the complex, multi-faceted needs of our poor and minority citizens.

These problems must be attacked simultaneously on a broad front. Several actions are required. For instance, greater investment in preventive services, reduced paperwork through administrative reforms, broader insurance coverage, and malpractice reform will surely help our poor and minority citizens. These actions are essential for improving minority health status.

But, by themselves, these changes will not be enough. As Dr. (Reed) Tuckson has pointed out, the values conveyed by our community institutions are vital in determining the health status of our citizens. Fully inclusive, racially representative, and

culturally sensitive hospitals, clinics, and other health care settings are crucial for improved health status in our minority communities. We need to make the health care system cognizant of the needs of minority citizens, and we have to build a greater openness and trust into that system. Otherwise, administrative reform and changes in reimbursement will have little impact on those who do not feel welcome in the system, or who have no access to facilities or to health personnel.

Unfortunately, our health care system is far from representative. For example, while over 12 percent of the nation's population is African-American, blacks were less than 8 percent of the nation's first year medical students, less than 6 percent of medical school graduates, and less than 3 percent of medical school faculty members.

We must also recognize that our minority communities have been excluded from the health care enterprise in other ways. There are a variety of factors that tell minorities -- "you are not welcome." Reimbursement for services often does not cover the true cost of caring for many minority and poor citizens, providing market incentives to first treat anyone but minorities and the poor. Surrogate measures of quality, such as the 50/50 rule in Medicare, often work to the detriment of our minority citizens. When discriminated against in forming health care systems, minority physicians do not have the clearly-defined right to sue. Few

health plans are minority owned, largely due to a lack of access to capital. Add it up, and the disincentives are staggering -- constituting a barrier to care that is covertly keeping large numbers of our most needy citizens from getting adequate and appropriate care.

One answer is to increase the number of physicians who are minorities. There is no adequate substitute for more Black, Hispanic, Native American, and Asian-American physicians. We must work to attract and train more minority nurses, physician assistants, and other members of the health care team. This requires more substantial investment in our nation's four historically black medical schools, including funding for infrastructure, education, out-reach efforts, policy studies, and biomedical research.

We also need a substantial and sustained proliferation of primary care services. According to the Council on Graduate Medical Education, by the year 2000, more than half of our nation's physicians should be primary care providers for the optimal delivery of appropriate health care. That means that the nation's current training rate of primary care physicians must more than double.

I must add that the deficiency of primary care providers would be much worse without the contributions of the predominantly black

medical schools. For example, the Association of American Medical Colleges reported last year that the Morehouse School of Medicine is the number one school in the nation in the percentage of our graduates in practice as primary care physicians. Nationally, only about 15 percent of all medical school seniors are choosing primary care fields for their careers. But at Morehouse almost 75 percent of the physicians we have graduated have chosen primary care fields, and more than 66 percent of our graduates practice in under-served areas.

Mr. Chairman, we must foster creative solutions that take health personnel beyond the four walls of the office or hospital room. We need to place health personnel in housing projects, in schools, in under-served rural settings, and other places that make health services readily accessible. We need to make the health care system more dynamic, more responsive, and more accessible through imaginative, realistic, and innovative actions. But I am very concerned that increasing standardization of health services may exclude the particular needs of minority patients. One safeguard would be to recognize that not all health institutions serve the same populations, and facilities operating in medically-distressed areas should be given more resources, rather than being fiscally squeezed. We need to expand our urban and rural outreach efforts, not eliminate them by funding all health settings by the same formula.

Finally, Mr. Chairman, we need to make the health system more representative, just, and equitable by removing the disincentives for physicians, administrators, and owners of health plans. I am submitting for the record a list of detailed actions that would help to ensure equitable opportunities for minority health care providers.

Mr. Chairman, we confront an historic opportunity for improving our health care system. Through your leadership, and through the continued efforts of Mr. Stokes, Mr. Lewis, Mr. Mfume, and others, we can make positive, lasting, and powerful changes in the health care system that will increase longevity, reduce disease, and prevent disability in our minority communities.

Thank you for inviting me to share these perspectives with you.

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Dr. SULLIVAN. Thank you, Mr. Chairman.

Mr. Chairman, we confront a historic opportunity in our Nation for improving our health care system. Through your leadership and through the continued efforts of others, including Mr. Stokes, Mr. Louis, Mr. Mfume, and others, we can make positive, lasting, powerful changes in the health care system, changes that will increase longevity, that will reduce the burden of disease and disability, the burden that is so overrepresented in our Nation's minority communities.

Thank you for allowing me to share these perspectives with you.

Mr. TOWNS. Thank you very much, Dr. Sullivan, for your statement.

At this time, I call on Dr. Tuckson.

Dr. TUCKSON. Thank you very much, Mr. Chairman.

And I, too, commend you and the committee for holding these hearings. I have submitted my written comments for the record. I will summarize my testimony: First by reminding all of us that the first responsibility of minority providers is to be concerned with and to protect the interests of our patients. Above all, everything we do must begin with that moral and ethical responsibility. Please, as you go forward with your leadership in enacting meaningful universal health coverage for all Americans, realize that the clock is ticking and the clock's tick has great consequences for our people. Seventy-five thousand African-Americans will die this year prematurely, in excess of what they would have died if the health of black people were the same as for white Americans, so that the implications of the time spent on the debate have their consequences in death, and we urge, absolutely urge the passage of universal coverage immediately.

Second, access to insurance though does not equal access to health care. There must be the providers, the facilities and the comprehensive array of support structures that are necessary to maintain and to protect health. Minority providers have a special expertise in these areas. Minority providers and minority health professional schools are a national resource. We have been the ones on the front lines caring for so many of those 37 to 50 million uninsured Americans. We have developed a particular and important set of knowledge regarding how to provide cost-effective, quality care to people that are multiply challenged and socioeconomically deprived. That is a very different set of skills and a very important set of skills than many other providers in this country have.

And so that as we look forward to health reform and as we approach these difficult subjects, it ought not be from a deficit model, but, in fact, from a position of strength. We know what we are doing. We have learned a lot and that is important to America and important then to preserve.

Much of that expertise by our providers has been developed, of course, in minority schools and then fed back to the schools by the graduates or by going to the conventions, such as the National Medical Association has convened over these many years. And so the interests of our patients, the interests of providers and the interests of our schools are all in concert.

Very quickly, I would suggest these few things in the few moments that remain: No. 1, if we are to train increasing numbers of

minority health professionals, we ought to really endorse the concept of 3,000 by the year 2000. By the year 2000, the percentage of African-Americans graduating should be 15 percent of all graduates in medical, dental, nursing, pharmaceutical, allied and public health professions. We should support programs that increase the number of health professionals by providing funds for enhancing existing or establishing new scholarships, loan forgiveness, mentoring, recruitment and retention programs. We should make financial awards to health professional schools and the priorities should be given to institutions with an established track record for training and graduating minorities.

We need to provide special financial incentives to African-American students who enter or are enrolled in programs at historically black professional schools and who agree, and who agree to work for no less than 3 years in an underserved area.

There is a responsibility and we hold our students to that responsibility. We should preserve and expand the numbers of minority disadvantaged health care providers through passing legislation reauthorizing—and Mr. Stokes has been a leader in this—the Disadvantaged Minority Health Professions Act of 1993. And as Dr. Sullivan has mentioned, and I would just take great pains to underscore, the necessity of providing biomedical facility construction support to these institutions. As the majority of schools line up to get the money from NIH and other places to build these gigantic buildings, we are left out and our students are trying to learn the important lessons that they are learning in trailers, too often, and in underfinanced facilities, and we need that kind of help.

In the 30 seconds that remain, let me second say that we need to recognize the shortage of minorities in all medical specialties and health-related disciplines. Dr. Sullivan is absolutely proud, with justifiable reason, of the record of training primary care physician at Morehouse, 75 percent of his graduates. At our institution at Drew, 73 percent of our graduates last year went into primary care.

But as we reorganize and realize there are too many physicians in America and too many specialists and not enough primary care doctors, let's not simultaneously turn off the production of minority specialists who are also needed, because comprehensive care demands a full access to the array of practitioners, and we have, you know, been too little with too late and now they change the rules of the game and our communities are the ones that are going to suffer.

And finally, I would strongly urge support, as others will today, for protecting essential community providers and leveling that financial playing field. The point I want to make, and I will conclude with this, sir, is that minority academic health centers must compete now with entrepreneurially minded, well-financed other hospital systems for our ability to retain our patient base, to do the teaching, to do the clinical research, and to be able to have our practice plans that help offset the cost of medical education.

We are very concerned that when the playing field is unlevel, we have a difficult time to compete and then we are carrying the anvil of education responsibilities on top of that, it makes it very, very

difficult. And so the essential community provider provisions that you will hear are very important to us.

I would say in conclusion, sir, that health reform is important. It is important that we find a way to afford to take care of those who have been disadvantaged and disenfranchised from the system. I would say to you that we represent an important national treasure of information and we look forward to participating and making America all that it can be.

[The prepared statement of Dr. Tuckson follows:]

Mr. Chairman and members of the Committee, my name is Reed Tuckson and I serve as President of the Charles Drew University of Medicine and Science and Vice President of the Association of Minority Health Professions Schools (AMHPS). It is a pleasure to appear before you today to discuss the important impact of health reform on minority providers.

As a context to my remarks, let me express in the strongest possible terms the importance of urgently realizing a health care reform bill that guarantees universal access to health care for all Americans. Minority providers and minority health professions schools have a history of dedicated and principled service to traditionally underserved communities. We know perhaps better than anyone else the disgraceful human toll that accompanies lack of access to a coordinated, comprehensive health care system. We have seen too many premature autopsies and attended too much preventable human misery and suffering. These good Americans deserve better and have a right to so basic a human value as Health.

Despite the very important discussions that are occurring in this Congress, the health care industry is evolving rapidly and inevitably. State and local governments are already mandating significant changes in reaction to the need to diminish their health care cost exposure, particularly for medicaid patients. These changes have profound effects upon minority providers and their communities. Simultaneously, well financed hospitals and provider networks are engaged in very intense competition for control over large segments of geographical populations. Minority providers who have labored as "essential community providers", and who have suffered the financial consequences of working with a frequently poor and uninsured patient base, are at an extreme disadvantage in this competition. The playing field is far from level. The consequences are such that as we sit here this morning, the health care entrepreneurial infrastructure that will significantly determine the practice of medicine and the provision of comprehensive health care services for the future is being determined for communities all across America. Legislative attention to this reality needs to be swift and decisive if the legitimate interests of minority providers and their patients are to be preserved.

Much of the debate on health reform has concerned the necessity of providing access to care to the 37 to 50 million Americans who are without health insurance at some time each year. As important as access to health insurance is in the struggle for health, access to insurance does not guarantee access to health care. Providers who are willing and competent to serve in, and address the needs of, underserved communities must be available. They must be prepared to practice cost effective medicine that produces quality outcomes in association with a wide range of comprehensive partners to a complex and multiply challenged patient base. Minority providers have a demonstrated record of just such service to just such communities.

The Association of Minority Health Professions Schools is proud that our members have trained 50% of the nation's black physicians and dentists and 75% of the nation's black

pharmacists and veterinarians. Producing health professionals who are dedicated and competent to serve in underserved communities, and the development of new knowledge and innovations in the course of that service is essential to the missions of our schools. Given the growing mandate for health reform that results in expanded access to cost effective care that maintains and enhances quality, our missions are of national importance.

We are greatly concerned about our ability to continue the pursuit of our missions. First, an essential feature of health reform is its recognition that there are too many physicians in America generally, too few primary care physicians and too many specialists. However, there are also over two thousand medical shortage areas in America. Minority health professionals only comprise 3.7% of all physicians and 2.1% of all dentists in the nation. As we correctly seek to increase the relative distribution of primary care physicians to specialists nationally, care must be taken not to further limit the training of minority physicians who are severely underrepresented in all medical specialties and disciplines. Comprehensive health care requires a full array of trained and coordinated providers.

Secondly, Academic Medical Centers require significant access to a large patient base for the purpose of teaching, research and clinical practice revenue. The AMHPS schools are engaged in a difficult struggle to compete with entrepreneurial minded local health systems that do not have the attendant obligations of teaching and research, and that are much more heavily financed. The formulas for compensating the costs of medical education should be carefully determined so as to be fair and equitable to our institutions. Similarly, as with other "essential community providers" we require a leveling of the competitive playing field.

My specific recommendations are:

1) INSURE UNIVERSAL COVERAGE AND UNIVERSAL ACCESS TO HEALTH CARE FOR ALL AMERICANS:

- There must be a single standard of care which is not varied or limited by race, ethnicity, economic status, geographic location or pre-existing condition, and must provide all Americans with the same basic benefits package.

- Health care must be made available to all covered individuals and must be offered by culturally sensitive health professionals.

- Provide incentives to health professionals providing care in Health Professions Shortage Areas (HPSAs) such as credits against federal income taxes of $1,000 per month for up to 60 months.

- Give access to tax credits to physicians who are repaying a Public Health Service

(PHS) loan through service in HPSAs at the end of their PHS commitment.

2) ***PROTECT ESSENTIAL COMMUNITY PROVIDERS:***

- Require that health plans serving either medically underserved or health professional shortage areas [as defined by the Department of Health and Human Services under 330 and 332 of the Public Health Service Act] contract with "essential community providers" or demonstrate that they can provide the same health care delivery system that would be provided by the essential community providers.

- Require health plans to contract with essential community providers on terms as favorable as those under contracts with other providers. In addition, require health plans to reimburse the essential community providers no less than the reasonable costs rates required by 1833[a] of the Social Security Act.

- Afford essential community providers a right of action to ensure prompt and timely enforcement of the provision.

3) ***TRAIN INCREASING NUMBERS OF MINORITY HEALTH PROFESSIONALS:***

- Endorse the concept of 3000 by the year 2000. By the year 2000, the percentage of African Americans graduating should be 15% of all graduates in medical, dental, nursing, pharmaceutical, and allied and public health professions.

- Support programs to increase the number of minority health professionals by providing funds for enhancing existing or establishing new scholarship, loan forgiveness, mentoring, recruitment, and retention programs; and faculty development at health professions schools.

- In making financial awards to health professions schools, priority should be given to institutions which have an established track record for training and graduating minorities in the health professions.

- Provide incentives for more minorities to enter into the health professions including:

  $10,000 per annum grants to African American students who enter or are enrolled in a graduate health care program at an Historically Black Health Professions School for academic years 1994 - 2000; and who agree to work for no less than three years after graduating in an underserved area; AND

$5,000 per annum grants to African American students who enter or are enrolled in a graduate health care program at a majority institution for academic years 1994 - 2000; and who agree to work for no less than three years after graduation in an underserved area.

- Preserve, enhance, and expand the numbers of minority and disadvantaged health care providers through passing legislation reauthorizing the Disadvantaged Minority Health Professions Act of 1993.

- Implement the President's recommendation for the National Health Service Corps (NHSC) program of $400 million in funding for training minority health professionals. In addition, the NHSC must be expanded, with placements in urban and rural areas that include: medical and dental specialties; and setting specific goals and time tables to recruit, train, and place minorities.

4) RECOGNIZE THE SHORTAGE OF MINORITIES IN ALL MEDICAL SPECIALTIES AND HEALTH PROFESSIONS DISCIPLINES:

- Exempt minority academic medical centers from mandates requiring at least 55% of individuals participating Graduate Medical Education (GME) programs be trained in primary care. These institutions should be allowed to continue training specialists prepared to practice in the inner city and rural areas.

- Prohibit any reductions in indirect medical education payments.

- Reauthorize Scholarship and Loan programs f the Disadvantaged Minority Health Improvement Act, maintaining eligibility to all health professions disciplines.

5) SUPPORT ACADEMIC HEALTH CENTERS:

- Provide a special percentage subsidy to those meeting national needs, such as increasing the numbers of minorities in the health professions. Include a percentage for the number of underrepresented minorities in formula grants for undergraduate medical education training.

- In any award of federal grants for the development of managed care networks to serve medically underserved areas, priority should be given to an application submitted by, or in conjunction with, a historically minority medical school.

- Make Historically Black Health Professions institutions eligible for "essential community provider" infrastructure grants.

Mr. Chairman, the Association of Minority Health Professions Schools supports the recommendations established by the Congressional Black Caucus in it's "African American Community Requirements of Health Care Reform: Consensus Provisions and legislative Priorities". We are proud to have worked closely with the CBC, Summit '93, and other African American organizations in the development of these recommendations. It is imperative that any health care reform legislation that is agreed upon by Congress be sensitive to the express needs of minority communities and be cognizant of the potential impact an overhaul of our nation's health care system can have on our health care providers.

As I mentioned earlier, the changes are already occurring, and minority providers are, in many instances, finding themselves closed out of the developing system. Measures that will provide security to the health professionals in our communities must be adopted so that we may be insured a level playing field once health care reform firmly takes hold.

Thank you for the opportunity to present the views of the Association of Minority Health Professions Schools.

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Mr. TOWNS. Let me thank both of you for your testimony. I think you were very informative.

Let me begin by raising a question with you, Dr. Tuckson.

How do we level the playing field? What suggestions and recommendations do you have?

Dr. TUCKSON. Excellent question. First, some of the ways, and you will hear others from others, but some of the ways is that in the contracting of—that networks do with providers, that there ought to be some safeguards and provisions, that essential community providers must be contracted with for some period of time and that those providers be willing to play by the rules of cost-effectiveness and quality.

We are not talking about second-rate medicine here, but we are saying that there need to be some special provisions, especially regarding monitoring of antidiscrimination provisions.

Second, there ought to be available a fund of money that allow minority providers and essential community providers the opportunity to get the technical expertise and the computer systems and the marketing systems to be able to compete level on with those that have been getting fat off of taking care of those with resources all of these years, and so I think that that is a specific way.

There ought to be grants available that allow us to buy the computers and to buy the management infrastructure that is so essential to being able to be competitive in this new world.

Those are two specific ways, and I think they go a long way.

Mr. TOWNS. Thank you.

Dr. Sullivan, you want to add anything to that?

Dr. SULLIVAN. Well, I think Dr. Tuckson has made the main point. I would say that certainly this means a response from the Federal Government, as well as from the private sector.

What we find when we look at the private sector is that when we go to foundations or to corporations seeking support, the same foundation that may give a $10 million grant to a majority institution, might give a $50,000 grant to a minority institution and expect the same outcome from that institution, given that less resources.

Having just finished in a tenure as Secretary of Health and Human Services for 4 years, the longest tenure of anyone in history, and having worked to increase the NIH budget by some 40 percent during my tenure, I was astounded at the response to efforts of my faculty to develop a neurosciences research center. We were insulted by the suggestion from my colleagues at NIH that we should partner with a majority institution to do this.

In other words, the concept is still there that in spite of whatever measure of achievement one attains, that still one is not recognized for that. So it really requires a change of attitude.

I could go down the list of those things which we have done at Morehouse that I think we are very proud of. We have operated every year without a deficit budget. We have a faculty that is very successful at competing for NIH grants, but when it comes to discretionary decisions, we constantly find ourselves at a disadvantage, whether it is working with our colleagues in the Federal Government or when we approach private sources.

So that is really what we are saying. We need to be looked at with the same objective criteria, not put at disadvantages, not have constant questions raised in spite of measures of achievement when one can demonstrate that.

For example, again, questions I would raise when I was asked by President Bush to join him as Secretary of Health and Human Services, some of the questions were: How could someone from a small minority institution manage the Federal Agency with the largest budget?

The reason I cite that tenure, the longest tenure for a Secretary at HHS is 19 months and usually those Secretaries leave under less than happy circumstances. Well, I demonstrated during the time we could manage that Agency.

So what I am saying is, we need to have those achievements by minorities, whether they are in practice, in administration, in research, in teaching really recognized so we don't have to constantly reprove—prove ourselves over and over again. We need to be given the same access to resources.

We want to participate fully in the development of the American dream. We want to contribute not only to minority issues, but to the wider society as well.

So that is what we mean by the level playing field. So I support Dr. Tuckson's comments.

Mr. TOWNS. Let me thank both of you for your comments, your testimony and your comments.

At this time, I would like to yield to the ranking member, Mr. Schiff.

Mr. SCHIFF. Thank you, Mr. Chairman.

Mr. TOWNS. For any questions he might have.

Mr. SCHIFF. I have a few questions.

Gentlemen, I appreciate your testimony very, very much. I do, however, want to set out and get rid of the "Q" question, quotas. In promoting the increase in the number of students and medical school graduates of minorities, are either of you advancing the suggestion—I didn't hear it in your list of suggestions, but I would like to ask, Are either of you suggesting a specific quota in medical schools that a certain number of seats be set aside specifically for certain members of minority groups?

Dr. SULLIVAN. No. No; we are not suggesting that at all, Congressman Schiff. We are suggesting equal opportunity, equal access.

My institution is a minority institution, but we are proud of the fact that we are really an integrated organization. Over the years, 80 percent of our students have been black, but 15 percent have been white; 5 percent have come from other minorities, Hispanics, native Americans, and Asian-Americans as well. But we recognize the special focus of our institution in addressing the health needs of minorities.

And let me also add that the first class we admitted in 1978 was a class that we offered acceptances to in April of that year; that was because we received our accreditation that year, so that allowed us to go forward in offering places to 24 students.

Because all medical schools fill their classes by January 1 of the year for the coming fall, that meant in April 1978 we had, among

applicants to choose from, those students who had not been successful in gaining access to other schools, and we brought in 24 students that year. We opened as a 2-year school.

Those students transferred 2 years later to many of the same schools they had not been successful in gaining entry to, including Emery, Brown, Rush Medical School, and others around the country. Many of those students then received academic honors when they graduated.

One student who went to Emery received the Kaiser Foundation Award for Academic Achievement. She subsequently became chief of pediatrics for the Emery Service at Grady Hospital. And I cite that to say that we recognize—we have the ability to recognize quality and talent in people that other institutions pass over, and then when indeed we bring those students in and give them the opportunity, then they are able to perform very well by many—by national criteria.

Mr. SCHIFF. But in terms of the ideas that you have proposed, you and Dr. Tuckson also, in terms of reaching out to the minority community, trying to be more—develop more students into the medical profession, which I agree with, it is my understanding, however, that if you look at the whole educational chain, the dropout rate in high school of minority students exceeds the dropout rate of the majority community, and it seems to me, but I would like your reaction, that as long as there is an imbalance that far down the pipeline, that you are not going to see the parity—there is going to be trouble, I should say, getting to the parity at the end of postgraduate education.

I would like to know if you agree with me, and if you do, what you would do down at the beginning of the educational pipeline to try to reduce the dropout rate.

Dr. TUCKSON. What a wonderful opportunity to say one of the best things about what we do in our schools is that we spend an enormous amount of our very limited resources on just developing that pipeline.

At Drew University in south-central, Los Angeles, we start right on our campus with children 3 months to 3 years of age, connected to the only—one of the only universities that runs a Head Start Program, kids 3 to 5 years of age. We have over 1,500 kids in Head Start.

Then at age 5, they graduate into our Saturday Science Academy. These are children from south central L.A., wearing white coats, all called doctors, sitting in every available seat in our campus, learning about science, dissecting dogfish shark, drawing the circulatory system and the anatomy, and learning to use the otoscope and the ophthalmoscope.

Then when they graduate at 14 from Saturday Science Academy, they go to our medical magnet high school on campus, walking across the campus every day to the hospital with their short white coats on. Then when they graduate from that, they either go to undergraduate college or into our allied health school.

This year's medical school class will graduate—will have in it our first graduates of the medical magnet high school and then they go on to a postgraduate residency training program and then teach the children that are coming behind them.

So, I absolutely would suggest to you that the notion of the 3,000 by 2000 that I mentioned, is a fundamental commitment and priority for us and that is why we say we need to support those kinds of initiatives in developing the pipeline.

But I would say this to you, Congressman Schiff, and you are so perceptive in your question, that is why these minority institutions are so important, and we are doing that with volunteer labor. We are doing that with no real national support. That is no taxpayer money. That is just us busting our cookies to make it happen. We need some help.

Mr. SCHIFF. I have to remember that busting our cookie.

Dr. SULLIVAN. Congressman Schiff.

Mr. TOWNS. That is a question that was fed to him, I think. He was looking for that one.

Mr. SCHIFF. I think it is a critical question. I am very impressed with Dr. Tuckson and the institution, and other institutions are already on top of that. I have one more matter I would like to add.

Dr. SULLIVAN. Let me say, certainly Dr. Tuckson and the Drew University really are providing real leadership there, but the other minority schools have similar programs. We have, for example, at Morehouse, a program also working with elementary and high school students. We do have funding for this program from the Howard Hughes Medical Institute. It is not—it is not enough, but we have that.

But, yes; that—you are absolutely right, that the pipeline problem is there, and we are not going to eventually get to where we need to be until we solve that, but we are all working on that.

One of the things that is in the Disadvantaged Assistance Program in the Health Careers Opportunity Program in the public health service, are funds for programs like that, but, again, those funds are not enough. Those funds are one-twentieth what they should be for us to be effective in doing that, but you are absolutely correct.

Mr. SCHIFF. I may be an undue optimist, but I believe if we solve the pipeline problem, eventually we solve all the other problems. Eventually, enough people come through that will break down the other barriers, and as I say, that may be optimism that is not supportable, but I think that is the place, and certainly you are emphasizing at least that area.

I have one area I would like to ask about. I have more familiarity with the legal profession than I do with the medical profession, but from what I have seen, oftentimes when members of minorities, African-American, native American, Hispanics do get through the hurdles and do graduate from law school, they are often lured by the dollars, too, and once they are at that point, particularly the sacrifices that had to be made in most instances to get there, there is a lure to go to work on Wall Street and earn the larger dollars that can be earned as lawyers. And I wonder, is there some—especially with the emphasis in your testimony about racially sensitive, racially conscious—culturally sensitive hospitals and staffs, and so forth, I did hear the reference to more of your graduates going to primary medicine, but I would like to be more specific. Do you have any evidence that minority group medical school graduates serve

the minority community more than majority member graduates of medical school?

Dr. SULLIVAN. Yes; that data is established, that the Association of American Medical Colleges attracts the students, that is correct. That is, you have a higher percentage of minority physicians serving minority communities than majorities.

As I indicated, where we have 75 percent of our graduates who have gone into primary care, 66 percent are working in medically underserved rural and inner-city areas, so I think that is similar for—the lure of Wall Street and the lure of high dollars, certainly that influences minority graduates as well, but I think you will find a higher percentage of minorities are concerned about their communities and serve their communities.

Let me use a personal example again. Having been Secretary of Health and Human Services, I chose to go back to Morehouse School of Medicine because I believe in what we are trying to do, and I am not making the income that I would make going elsewhere, but I am making a decent living. I am not crying poverty, but certainly one has to be committed to what one is doing, and I think the same for Dr. Tuckson. We are committed to addressing those things in the minority community.

There are many minority providers who are in the minority communities rather than going elsewhere where they could earn higher income.

Dr. TUCKSON. An example is the National Medical Association and its membership, I think, is eloquent testimony, as you—and Mr. Stokes knows and Mr. Towns, as they attend the convention and they see those physicians and they see what their practices are.

The record is very clear and, if anything, that is why again I am able to speak with such pride about what minority professionals are able to accomplish in this country and what they mean to America. They are examples of the American ideal.

Mr. SCHIFF. I want to thank both witnesses for your excellent testimony. Thank you for being here.

Mr. TOWNS. Thank you very much. The gentleman's time has definitely expired.

But I just want to indicate to you what I have done, when we had Congressman Stokes, we did not use the light because, let's face it, when we are dealing with persons that involved, we don't want to use the light. We want to sort of have the time. And when we are dealing with two presidents of medical schools, we do not want to use the light.

So let me just say to the members, we don't want to use the light with these two, but, of course, after this, we will be using the light. So this time I—before we do that, let me call on Congressman Stokes and then I will go to Congressman Portman next.

Congressman Stokes.

Mr. STOKES. Thank you for letting me get in under the light, Mr. Chairman.

Let me ask Dr. Sullivan, having been former Secretary of Health and Human Services, there is some discussion among some groups about requiring the Secretary of Health and Human Services to establish Federal standards for the certification of managed care

plans, and one of the proposals would require the plans to disclose the criteria that they use to select and exclude physicians from their networks.

The proposal would not allow a doctor to be dismissed without cause, and I just wonder if you would comment on the merits of this type of proposal as it might affect African-American health care providers.

Dr. SULLIVAN. Thank you, Mr. Stokes.

I think a provision such as that is absolutely essential. I have been told of too many instances around the country, including my own city of Atlanta, where managed care plans have come in and have not included minority providers among their network of providers. So indeed, I think that we are absolutely concerned that there have to be Federal standards to ensure that there is fairness and equity in this process. And I would emphasize that we want to see not only minority providers, but minority owners of health plans, minority administrators, and health policies.

In other words, we want to see minorities not simply in positions providing service, that is important, but we also want them in the decisionmaking policy positions so that that way we can ensure we have a system that has built in the cultural sensitivity to see that the needs of the community are met.

Mr. STOKES. Mr. Chairman, if I could just ask one other question to Dr. Tuckson.

Dr. Tuckson, I think you have raised a very important issue in terms of 3,000 minority physicians by 2000. And, of course, in terms of looking at health care reform legislation, one of our concerns is how do we achieve that, in recognition of the fact that minorities are 12 percent of the total population, yet we are only 3 percent of the Nation's doctors, and that is sort of compounded or exacerbated by the fact that the four historically minority medical schools, Howard, Morehouse, Meharry, and Drew, I suppose train in excess of 50 percent of minority doctors that come out of school every year; is that figure correct?

Dr. TUCKSON. Close to it anyway.

Dr. SULLIVAN. Historically, that has been the case, though, in recent years, that—as more majority schools have accepted students, that has fallen below 50 percent, but if you look at those who are in practice today who are the products of the educational system 10, 20, 30 years ago, indeed more than half.

Mr. STOKES. So what we are moving toward then in its natural course is trying to get more minority physicians by utilization of both systems, both historically minority schools and the majority schools; Is that correct?

Dr. TUCKSON. Yes, sir, that is exactly correct, and it is—and of in my specific testimony, we lay out the very detailed solutions, which I know we don't have time to review, but they are everything from the pipeline that Mr. Schiff emphasizes, all the way through to the way in which we develop loan forgiveness programs and scholarship programs and those sorts of—the National Health Service Corps and those programs being expanded. There are a variety of ways that we can approach this to make it occur.

Mr. STOKES. Thank you, Mr. Chairman.

Mr. TOWNS. Thank you very much, Congressman Stokes.

At this time, I yield to Congressman Portman.

Mr. PORTMAN. Thank you, Mr. Chairman.

I appreciate your both being here this morning and your good testimony.

Good to see you again, Dr. Sullivan.

I don't know how you made it through 4 years. I congratulate you. I made it through 2 myself over in the Bush White House, but I really enjoyed the testimony.

Again, I see some parallels to some of my underserved rural counties, some of the concerns you raised.

Following on Mr. Stokes's comment with regard to managed care, it is my belief that whether the Congress finds the will to proceed with health care reform or not, the managed care will be increasingly evident, both in the rural counties that I represent and in the urban areas. It is my view that the every willing provider laws that some States have is going to continue to be a major issue, if it is not resolved at the Federal level.

And I guess my question to both of you, particularly Dr. Sullivan having answered the previous question, is going sort of beyond what Mr. Stokes asked, What is your general view about every willing provider laws? Do you believe this would solve the problem or does there need to be something more specific as to minority representation?

Dr. SULLIVAN. Well, thank you very much, Mr. Portman, for your comments. It is nice to see you here. I think that certainly both are needed, that is, any willing provider is important because, again, the experience has been, again, from many personal instances that have been brought to my attention, has been that many managed care operations have indeed dismissed physicians or not included them without giving a rationale, without ever explaining what were the criteria or what were the reasons therefore. That is not fair.

We have to have a system that is fair, and that really is the basis for the willing provider clause. Clearly, the provider agrees to abide by the rules of the HMO.

Second, the essential community provider provision is necessary because, again, in my view, there are many, sometimes inadvertent ways that minorities are not included in it. My colleagues in the AAMC, of course, are very concerned about perhaps a new fund to support medical education. And I have seen the criteria that have been developed. But not a single criterion among those developed addresses the issue of rewarding medical schools for increasing the number of minority students or minority graduates.

Although the AAMC since 1968 has been on record by vote of the assembly, of urging the increased number of minority students and graduates, and of course, 39,000 by 2000 program is an AAMC initiative. So the goals and the rhetoric is there, but we have to have the teeth or the specific implementation steps to see that those goals are met.

So, yes, I think that those physicians and other providers who have worked in these communities and who now are often seeing themselves bypassed, as now there is a scramble into these communities because everyone now anticipates there is going to be dollars to pay for these services, that clearly those who are coming in now

are motivated more by dollars, whereas those who have been there all along have been motivated by a personal commitment. We want to make sure that they are included.

Dr. TUCKSON. Just 10 seconds.

I just also urge you to think about them. As we look at the criteria by which we will judge quality, and particularly in those who have been disadvantaged and disenfranchised from the system, we have a lot to learn in this country about quality of care and what that means, particularly in socioeconomically challenged people. The development of the health services research and quality outcomes measures that is now so much a part of the growing—of health care reform is an area of expertise that the—that the minority health professions schools must continue to participate in and be given the resources so that we can develop those criteria.

How we judge and evaluate whether or not a physician has done a good job cost effectively and ought to deserve to be in that plan is an area that we are still, as a Nation, very naive about, and that is in a burgeoning area of research which we ought to be part of the leadership in.

Mr. PORTMAN. Then the private sectory ought to take a leading role in developing that criteria?

Dr. TUCKSON. And we—the private sector in the academic private sector world; that is absolutely right. And we have the knowledge, expertise and experience to do that. We just want a chance to be able to do it.

Mr. PORTMAN. One other quick question, Mr. Chairman, and that relates to the primary care, going back to some of the questions Mr. Schiff had, and so on, in terms of underserved areas. One question I have for both of you, I think at Morehouse, 75 percent of your graduating doctors are going into primary care. I think 73 percent you said, Dr. Tuckson. What are you doing? What are you doing right to come up with those kind of numbers?

I represent an area that includes the University of Cincinnati Medical Center which is a well-known regional medical center. We don't have numbers like that. What are your two institutions doing, do you think, from your experience that make it different?

Dr. SULLIVAN. Well, well, I think we are doing a number of things, Mr. Portman, that—not one of them can we, say, single out, but they include such things as, first of all, we have a well-published mission that students who are interested in coming to our institution, this is what we are about.

We also give preference to students who come from medically underserved areas because the data show that students who come from medically underserved areas have a greater likelihood of going back, if not to that same area, but to another underserved area. We also, during the time students are with us, keep before them the fact that they have a unique opportunity and responsibility to the American people, that is to use the medical education which they have the opportunity of getting, and which their tuition pays only a fraction, and therefore the taxpayer, corporations, foundations, and individuals also are supporting their ability to get that medical education, that they have a responsibility there.

And finally, the challenge of leadership, we tell our students that their role is not simply as physicians, but to be community leaders,

to recognize that they have an education that 98 percent of the rest of the population does not have. That brings with it responsibility to use that education for the broad benefit of the community. We have a committed faculty that works with our students. So it really is the mission, and how that is inculcated in the student.

I was a student at Boston University in the mid-1950's, and I can tell you, when I told the faculty that I wanted to become a primary care physician, go back to be a family doctor in Georgia, in essence, I was told, sat down by the professor of anatomy, and said, in essence: Why are you wasting your career?

That is the kind of thing that the research-intensive schools have. You have a culture in the research-intensive schools that is very different from the culture of those schools that are committed to primary care. Students recognize that this can be a fulfilling, rewarding position. And here again, while the incomes they have as primary care physicians are far from what they would have as specialty-oriented physicians, they still are reasonable incomes. We are not asking our students to take vows of poverty.

But we are asking them to be committed to a meaningful profession where they will make a difference in the lives of others, rather than being simply concerned with the size of their wallet. And our students buy that. They come to medical school because that is what they want to do.

Mr. TUCKSON. In the interests of time, ditto.

Mr. PORTMAN. Very thorough answer.

Thank you, Mr. Chairman.

Mr. TOWNS. Thank you very much. Let me thank both of you for your testimony. You have been extremely helpful. Thank you very, very much.

STATEMENTS OF DR. EDWARD A. CHOW, MEDICAL DIRECTOR, CHINESE COMMUNITY HEALTH PLAN; KAREN CLARK, PRESIDENT AND CHIEF EXECUTIVE OFFICER, MANAGED HEALTH CARE SYSTEMS OF NEW YORK; DR. AMARILYS CORTIJO, MEDICAL DIRECTOR, BROOKLYN MEDICAL GROUP, HEALTH INSURANCE PLAN OF GREATER NEW YORK; DR. CLYDE ODEN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, WATTS HEALTH FOUNDATION, INC./UNITED HEALTH PLAN; MS. LEIGH BROCK, PERSONAL PHYSICIAN CARE, INC.; AND JAMES TURNER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, TOTAL HEALTH CARE PLAN, INC.

Mr. TOWNS. Our next panel is Dr. Edward Chow, Ms. Clark, Dr. Cortijo, Dr. Oden, Dr. Brock, and Mr. Turner.

Why don't we begin with you, Dr. Chow.

Dr. CHOW. Thank you, Mr. Chairman. I thank the chairman for inviting me to this panel on this very important subject. Let me say that on behalf of our Asian-American community, we are appreciative that we are called, as often we are considered the silent minority, but we are a minority of about 7 million people here in the United States, and have grown, nearly doubling our population from 1980 to 1990.

It is a minority that appreciates being listened to today in terms of how they access health care. It is the minority that has approximately three-quarters who are really foreign-born, and have,

through the ability of the generosity of the United States, come to the United States to be able to bring their talents to our country.

It is a minority, however, that is not always as perfect as perhaps the aggregate data shows. It is the minority that is based on a multicultural, multilinguistic group that by census data has come together rather than in any other logical fashion, with nearly 40 or 50 different languages that are necessary to access and to be able to understand people who for 40 to 50 percent of those who are here now prefer their native language, or need to have their native language as they are learning English.

The new answers of trying to understand medical issues, particularly, involve the necessity to be culturally competent.

I am also proud to be able to come then to bring a small example of how this community—how this Asian population, through a small community program, might in fact represent another answer to how minority propositions could be served who have this extremely important need of cultural competence.

The Chinese Hospital of San Francisco began in the early 1900's because its population could not be accepted into private voluntary hospitals and the county hospital was very far away, and also did not have the ability to speak to the people or understand the people as they attempted to access western medicine.

So in 1925, the community built its own hospital and opened this for the public, a community facility which today is still operated by a board of directors elected from such a diverse group as family and district associations, the YMCA, and even the Chinese Christian Union, all major organizations in the 1920's who said it is time to bring western health care to our Chinese.

At the end of the century, as we are approaching the end, the same community concern arose as health care in California was swept by the managed care movement, one in which then the lowering of costs for managed care programs and its effectiveness in bringing about better care, in fact then also unwittingly left out a large part of our population who, while members of or employees of larger corporations and middle-sized corporations were being forced into programs which were not deliberately, but unwittingly culturally insensitive.

Medicare's own movement toward the capitated programs also moved the elderly into less expensive low-cost programs, but then led them to no access, unfortunately, in understanding their critical medical needs. And so the Chinese Community Health Plan was formed from this necessity of both the hospital and physicians in the community who felt that it was necessary to answer that challenge. And from the experience, we have found that, in fact, the managed care process has been one that has broadened the ability for us to give good western health care to our community.

And one reason that I believe this true is because the system, the western system itself is difficult to understand as a true fee-for-service system, because it requires that you have enough knowledge of how to utilize that system, and placing them into the managed care programs allows us then to assist our patients, to get through that system, knowing that we have the resources and knowing that we can utilize those resources to their best ability.

Under that experience then, we would like to say that it would be important, we feel, to maintain those minority programs, especially in those areas that require special linguistic and cultural sensitivity, to be part of the health reform, or, in fact, health reform will not come to the Asian-Americans.

Simply having several members of the Asian-American community as physicians on a panel does not make cultural competence. Cultural competence in a system requires that from receptionist to radiology technician, there is the feeling of comfort on the part of those receiving care that they can be truly understood, and to compound that is the fact that many of our people are still in a dual medical system, with an overlay of folklore medicine.

And so let me then conclude by thanking you again for allowing me to bring the Asian-American concerns in health care reform to this committee. We look forward to the opportunity to have an expanded access through meaningful health care reform.

Thank you.

Mr. TOWNS. Thank you very much, Dr. Chow. Let me just sort of reiterate that when you start out, the light is on green, and when it turns red, that means that your 5 minutes have expired. So thank you very much, Dr. Chow.

[The prepared statement of Dr. Chow follows:]

EXECUTIVE SUMMARY

- The Chinese Community Health Plan (CCHP) is a for profit California HMO owned by the non profit Chinese Hospital of San Francisco which delivers affordable culturally competent managed care to the San Francisco Chinese community.

- The Chinese Hospital was founded because ethnocultural considerations required a culturally competent service to facilitate access of the community to western medicine, and private hospital policies in the early 1900s did not permit admission of Chinese to their facilities.

- The CCHP was organized because of the increased pressure on businesses to lower costs by providing less costly health benefits through managed care programs such as HMOs, government encouraging managed care Medicare programs, exclusion of hospital and physicians from providing care through such programs, and the need for the community to have access to lower costs through managed care products.

- CCHP has provided the community its own culturally competent integrated delivery system. The managed care approach assists many members of the community who do not know how to utilize the western medical system. The delivery system is also available to mainstream plans that desire to have culturally competent providers for their members.

- CCHP, the Chinese Hospital, and Chinese Community Health Care Association, the non profit mutual benefit association of the physicians, now serves approximately 9% of the Chinese population through CCHP and affiliated managed care programs. At the request of local physicians and facilities, CCHP will be expanding its services to Los Angeles county this month.

- The Asian minority population is the fastest growing population in the United States and in California represents nearly 10% of the population. In urban centers, it is a much higher concentration, and in San Francisco it represents nearly one-third of the population.

- Health reform needs to address the Asian ethnocultural needs if it is to enhance access and availability. Areas of potential concern include large HMOS ignoring small vulnerable populations, exclusivity of providers or facilities excluding minorities, credentialing standards excluding experienced quality minority providers, lack of cultural competence, and lack of support for infrastructure change for existing culturally competent private, community or public providers. Providers of care need to be "culturally competent" and sensitive to the different cultures and medical traditions.

- Managed care organizations such as HMOs should support and utilize existing culturally competent providers or organizations, or develop new providers if they wish to effectively serve the Asian population. Already existing high quality private, community based and public programs should be encouraged and provided assistance to develop the infrastructures necessary to participate as managed care providers.

- The CCHP may serve as a model for private and public sector minority health plans with an integrated delivery system and networking of its providers and facilities with larger managed care organizations.

INTRODUCTION

Good morning, Mr. Chairman and Members of the subcommittee. I am Edward A. Chow, the Corporate Medical Director of the Chinese Community Health Plan(CCHP), an HMO owned by the non profit community owned Chinese Hospital of San Francisco. I am also a practicing internist in downtown San Francisco, serve as a member of the San Francisco Health Commission, and as a member of the Multicultural Task Force advisory to the Director of Health of the State of California. I am also a board member of the California Medical Association and an advisory board member of Blue Cross of California.

I am here to present the experience of our plan in serving our minority. That minority is the San Francisco Asian community, a part of the fastest growing community in the United States. From 1980 to 1990, the Asian American population increased from 3.8 million to 6.9 million, an increase of nearly 80%. Nearly forty percent of Asian Americans live in California, and they comprise approximately 2.8 million people, or 10% of the state. In San Francisco, Asian Americans represent approximately one-third of the population, or 210,876, a 43% increase in ten years. There were 127,140 residents of Chinese descent in San Francisco in 1990.

Asian Americans are a diverse group. However, as a group, their needs are compounded by language and cultural isolation in many communities. They are often thought to be a model minority, but in fact, if broken down by ethnicity, birth status, and economic status, significant numbers of Asian Americans have major health problems. For example, the Chinese have increased rates over the white population in hepatitis B, carcinoma of the liver, esophageal cancer, thalassemia, and tuberculosis.

Up to 12.6% of Asian Americans are below the poverty level. The unemployment rate for Asians and Pacific Islanders is 6.6% in males and 5.7% in females, but below minimum wages are often the norm in the sweat shops, sewing factories and restaurants. The per capita income of Asians and Pacific Islanders in San Francisco is $12,665, 35.7% below the average per capita income, and 51.7% below that of the white population. Over 26,420 Asians in San Francisco were below the poverty line. It is estimated that about 15-20% of Chinese in San Francisco are on the Medi-Cal program.

Many Asians are restricted by their language and are monolingually isolated. Over forty percent of Chinese in San Francisco consider another language than English as their preferred language. Over 59% of those 65 and older are monolingual.

CHINESE COMMUNITY HEALTH CARE PLAN (CCHP)

The Chinese Community Health Plan (CCHP) is a for-profit health maintenance organization, licensed by the Department of Corporations of the State of California. It is a wholely owned subsidiary of the Chinese Hospital Association, a non profit organization which also operates the sixty bed Chinese Hospital. The mission of the CCHP is to offer culturally sensitive, high quality and affordable managed care programs to the community. It therefore offers both individual and group programs. The current enrollment of CCHP is approximately 6,500, almost evenly divided between group enrollment and individual enrollment. The majority of the groups are relatively small companies, such as garment factories or restaurants and art goods stores, along with small family operations. Many of the individual members who are employed at small companies that do not offer health insurance.

The CCHP was developed by the Chinese Hospital Association board of trustees and members of the medical staff in response to a growing need to offer culturally sensitive managed care programs in our community. The Chinese Hospital itself had been built by community leaders in 1925 in response to the need to provide culturally competent access to western medicine in the then largest Asian community in the United States. In 1900, the community first opened a clinic for western medicine. Later, as it became apparent that many hospitals would not accept Chinese patients, and the city hospital was many dusty miles away, the community with funds raised from throughout the United States and China built the Chinese Hospital. When the institution first opened in 1925 it was hailed as the most modern hospital in America. For over fifty years, it was the only hospital in the United States owned by the Chinese community and served the Chinese in San Francisco including the poor and indigent. The building became obsolete and not up to seismic standards and in 1979 was replaced with a new modern structure bringing up to date technology and modern conveniences to allow continuance of the work of this important community facility.

By 1980, the community had become one of the most densely populated areas in the United States, second only to Manhattan in New York City. Immigration had brought new residents and new responsibilities for the hospital. The new hospital building in 1979 was a milestone in the community. However, the hospital board and medical staff noted that many Chinese were no longer able to access care through community practitioners. Traditional indemnity insurance was becoming unaffordable, and many residents were uninsured or underinsured. Employers and other health care purchasers, attempting to limit their expenditures, were offering alternative health care programs to their employees with limited panels of physicians and hospitals. This phenomenon was particularly depriving the monolingual Chinese worker of accessibility to local, bilingual, culturally sensitive health care since few of these programs included providers in Chinatown, and none were truly responsive to the immigrant and monolingual population. There was a steady migration of the working class to health facilities away from the community. Medicare elderly also were taking advantage of a new Medicare capitated program (CMP) sponsored by another hospital due to its low cost and less hassle. Unfortunately, the program could not serve the elderly well as it had limited linguistic and cultural support.

The Chinese Hospital and medical staff also faced a stark reality when a city-wide HMO in formation, started by community hospitals and medical society, effectively excluded the Chinese Hospital and its staff from participation by requiring equal capital contributions from large and small facilities.

The board and medical staff felt community care would suffer if the community were forced to get its care through managed care organizations which did not have cultural and linguistic capabilities and identified the need to become involved in managed care and develop an HMO so that the Chinese Hospital could continue to serve the community by providing the cultural competency necessary to make western care accessible. With the initial help of Blue Shield of California, an Exclusive Provider Organization (EPO), an HMO look-alike, was started in 1984. The medical staff also formed a non profit mutual benefit association, the Chinese Community Health Care Association,(CCHCA), with the intention that any residuals would be used for health promotion and support for the community.

At the same time, Children's Hospital, a child and adult facility in the western part of San Francisco desired additional patients from the Chinese community. The hospital approached members of the Chinese Hospital staff for a few primary care practitioners for their health plan which included a Medicare CMP. The Chinese Community Health Care Association (CCHCA) offered their services as did the hospital as partners with Children's Hospital. This began another experiment to open access for the population under managed care using culturally competent providers.

These experiences demonstrated that the hospital and physician group could work together in a

managed care environment and led to the Chinese Hospital Association's pursuit of its own HMO license. The Chinese Community Health Plan was licensed by the California Department of Corporations in 1987, beginning a new way in which the Chinese Hospital Association would carry out its mission to provide access to western medicine for the community.

Believing that linkages to larger HMOs with regional and statewide affiliation also offered access to the culturally competent delivery system which had been developed by Chinese Hospital and the CCHCA, this July, CaliforniaCare, the Blue Cross of California HMO, was added to the options offered to the community with physician care provided by CCHCA, hospital care through Chinese Hospital, and utilizing CCHF as the business administrator.

Today, the Chinese Community Health Plan through its own program, and as a third party administrator for the hospital and CCHCA "mainstream" programs serves over 11,000 members, representing approximately 9% of the overall Chinese community, and approximately 15% of the available market share.

The CCHP in extension of its mission to serve the community has recently successfully completed application for its own CMP license for Medicare and has an application pending for state approval as a Medicaid prepaid health provider (PHP).

CCHP is also expanding this month to the Chinatown and Monterey Park areas of Los Angeles at the request of the local physicians and interested hospitals who wish to provide culturally competent care. CCHP will also provide support and assistance to the over one hundred member physician group in Los Angeles to provide managed care to the community.

The cooperation of medical providers was critical to the success of the CCHP. The Chinese Community Health Care Association was established as a non profit mutual benefit association and is an IPA like vehicle to deliver care to the community with over one hundred and twenty physicians, almost all bilingual, and representing nearly every specialty. Yearly, nearly half a million dollars in grants and support are donated to provide twenty four hour treatment room service for the community, no cost community education and nutrition counseling, a bilingual health resource center, health newsletters and medical research.

MANAGED CARE AND THE ASIAN MINORITY

We are here because there is a health crisis in America and the Congress is responding to that need. The ideograms for crisis in the Chinese language include the characters for "danger" and "opportunity".

The Asian minority is in reality a number of minorities, joined by a common racial background, but separated by different languages and customs. In most of these cultures, there is a three-fold medical hierarchy, including "folk" medicine, "eastern" medicine and "western" medicine. While Asian Americans have been called a model minority, including their aggregate health status, a careful review of their health status by race, nativity, and economic status reveals a significant portion of Asian Americans who have needs similar to other vulnerable populations. Almost three quarters of the Asian minority are foreign born. Because of the ethnocultural barriers, there must be special competence to understand their needs.

Like all Americans, Asian Americans should benefit from the implementation of health reform principles including the delivery of quality care with (1) Universal Access, (2) Portability, (3) Availability by removing pre-existing exclusions, (4) Defined Benefit Package, and (5) Pluralistic choice, providing there is adequate choice of culturally competent providers, facilities and programs.

MINORITY SERVICES IN MANAGED CARE

There are several scenarios contemplated in health reform that make it important to pay special attention to ensuring access and availability of service to minorities. For example, in a system of unfettered competition, there is a potential for large HMOs and other managed care organizations to dominate the scene. Minority populations may represent only a small number of the members enrolled in such health plans and may not receive appropriate attention and culturally competent care. This may be partly due to their small number, and partly because the cost of delivering care to these populations may be high due to their health status and need for special support services. It will be critical to ensure that health plans, such as CCHP, that specialize in culturally competent services, be permitted to offer coverage in such a marketplace. Some legislative proposals would require that all health plans offer services throughout entire metropolitan areas. An exception should be permitted for health plans whose focus is on meeting the needs of vulnerable populations

Another potential scenario in managed care programs is the use of exclusive panels of providers or facilities which are not culturally sensitive. Health plans that serve culturally diverse populations should be required to ensure that their delivery systems provide linguistically and culturally appropriate services. Large health plans may need to make special efforts to forge successful linkages with culturally competent providers. Today, there are federal and community clinics and private programs such as CCHP that serve minorities in a culturally competent manner. As CCHP has demonstrated, such programs can succeed in a managed care environment and enrich the health plan choices available to minority populations. Health care reform should foster the participation of such programs, providers and facilities in managed care plans.

If managed care also brings about the merger of provider groups or programs into larger organizations, the interests of the larger provider organization may not provide enough support for culturally competent programs. A few ethnic or culturally interested providers in an organization of several thousand providers would have little opportunity or support to continue or develop culturally competent programs. Additionally, the provider groups may set certain standards which would be exclusionary for minority providers, such as requirements for board certification. Many minority providers are well trained in other countries, and may not have had the opportunity to obtain board certification. They may have delivered high quality care for many years but would now be excluded.

If managed care organizations or providers are seeking to care for minority groups, they should have appropriate cultural competency programs and encourage and support the development of culturally competent providers. Credentialing of minority practitioners should be reasonable and based on experience as well as academic credentials.

The opportunities that a managed care program could offer would be to increase accessibility to culturally competent programs. For example, when Blue Cross of California's HMO added the physicians from the Chinese Community Health Care Association and the Chinese Hospital to their network, it added a culturally competent delivery system of both hospital and over one hundred physicians. This opened the opportunity to CaliforniaCare members in San Francisco to access these services.

This can be mutually beneficial to both the larger HMO and the culturally competent delivery system. The QualMed HMO, the successor organization to the Children's Hospital Health Plan has access to the Chinese community through its affiliations with CCHCA and the Chinese Hospital; the CCHCA and the Chinese Hospital have the opportunity to care for QualMed patients.

The ability for culturally competent managed care providers and delivery system to participate in a meaningful way is critical to continued access by the targeted populations.

MINORITY PROVIDERS AND MANAGED CARE

There has been significant discussion about maintenance of quality minority programs and safety net providers by mandating their acceptance by plans. While it is important that the services of quality providers, including minority and safety net providers not be lost, such mandates would leave no incentive for such providers to learn new skills of medical management and improve utilization of their scarce resources. Private programs such as CCHP have learned the need to be cost-effective which allows for lower costs and affordable premiums. Public sponsored programs should benefit under the same discipline which should expand the care they can deliver with more effective use of current resources. Public agencies, federal, state, or county, must provide adequate capitalization to allow for infrastructure changes to achieve these savings. Opportunity must be given to these organizations to participate in providing the quality care for their special populations under a health care reform environment involving managed care.

The Medicaid managed care program in California is an example of a state experiment. The state has requested thirteen counties, with ninety percent of the MediCal population, to organize into managed care delivery systems utilizing current existing providers and has provided some funding to help develop part of the infrastructure. The state will also provide a second option for the recipients, with a "mainstream" plan in each county which will need to demonstrate cultural competence if the plan will be serving a significant minority or safety net population.

In San Francisco, the Department of Public Health is requesting resources to integrate the independent clinic system and San Francisco General Hospital's clinics so that primary care will be integrated and the department could compete in the managed care environment. The San Francisco General Hospital is also improving its medical delivery system, making better use of the dollars available to deliver care so as to be cost competitive when offering its services to managed care organizations. This consolidation and coordination should increase the amount of care being rendered for the dollars spent.

Private HMOs as well as government can help encourage this transition to a managed care environment. Blue Shield of California assisted the CCHP. More recently, Blue Cross of California has assisted the development of four ethnic minority community-based provider groups, including two Asian groups. CCHP will now be assisting in the continued development of its Los Angeles provider group.

Maintenance of the status quo would not stimulate these providers to improve the effectiveness and efficiency of these provider groups when using a managed care technology. HMOs and governments must be willing to support these efforts.

Effective carefully nurtured programs to serve the minorities and other safety-net providers should not be forgotten or abandoned. However, it would not be good public policy to mandate the acceptance of "essential community providers" without qualifications. To maintain programs that are not cost effective and efficient is self defeating. These "essential providers" must be given the opportunity and resources to develop the infrastructure necessary to compete. There should also be recognition of the special needs and resources for those providers that provide care to special communities. Placing special populations into the mainstream of delivery systems should not reduce society's obligation to support these safety net recipients.

MEASURING QUALITY CARE

Quality of care is of paramount importance. The measurement of quality of care in a multi-langauge environment with many monolingual consumers is difficult. Conventional methodology such as

environment with many monolingual consumers is difficult. Conventional methodology such as telephone surveys, or questionnaires may not be effective in these communities. *Methodologies to measure the quality of care in minorities should be validated.*

MEASURING CULTURAL COMPETENCY

The State of California in its Medicaid managed care program is implementing a cultural competency standard. The state defined cultural competence as "the capacity of individuals or organizations to effectively identify the needs and preferences of target populations; to design programs, interventions, and services which effectively address those needs; and to evaluate and contribute to the ongoing improvement of these efforts." The state is currently developing means to define the standards to measure the extent that plans fulfill those needs for the state's diverse ethnic Medicaid population. Currently, CCHP and a Latino Medicaid HMO are working with the author of the cultural competence standards to validate certain cultural standards.

Managed care organizations will need guidelines as to when or how to meet the needs of local communities. These should be developed cooperatively with health care providers and community organizations, and be required when a significant part of a vulnerable minority is being served. The California experience may be a valuable example.

CONCLUSION

The Chinese Community Health Plan illustrates the opportunities a community can use to improve the delivery of care by integrating the delivery of care and assisting in the management of medical services for its members. The Chinese Hospital board, working together with its medical staff developed CCHP which serves the community by offering culturally sensitive and affordable health care through its own plan and through other plans as subcontractors. The managed care approach assists many in the community who do not know how to utilize the western medical system to receive coordinated care and appropriate referral services.

For the future, recognizing that a critical mass must be present to meet our community needs more effectively, and to encourage the coordinated and effective use of skilled culturally competent provider programs, CCHP, the physicians, and hospital, are also working together in NICOS Chinese Health Coalition (NICOS). The coalition includes nearly twenty major health and human service providers in the community, including On Lok Senior Services, a national model HMO for the frail elderly, Northeast Medical Services, a federally qualified health center, Self Help for the Elderly home health agency, the district health center, schools, mental health and substance abuse programs, and children child care programs. NICOS serves as a community forum for health care issues. For the past five years, with funding from private foundations, and in collaboration with housing agencies, it has developed and coordinate a model bilingual community disaster response program. Incorporating as a non profit association this year, NICOS will study the feasibility of a city wide culturally competent integrated delivery system which would be available to health plans or others that which to serve the Chinese community.

I thank you for the opportunity to share with you the experience of the development of the Chinese Community Health Plan, and how it meets our community's health needs.

Mr. TOWNS. At this time, Ms. Brock.

Ms. BROCK. My name is Lee Brock and I represent Personal Physician Care, a local HMO in northeastern Ohio, which is both physician owned and operated. We were formed in 1986 in response to minority physicians in our area who are not allowed access to the majority insurance companies.

Our physician provider network consists of board-certified and board-eligible physicians who function both as primary care and specialty physicians. The network currently consists of over 600 health care providers dedicated to delivering quality care and comprehensive health care. Our challenge is to continue to build our network of providers that will promote as well as provide cost effective and quality care.

The key to our successful managed care program is to stress preventive care. Our physicians are obligated to avoid unnecessary and inappropriate care that increases costs and contributes to our national health care dilemma.

Specific incentives to retain African-American physicians who are not now a significant part of managed care programs should be developed. Training of African-American primary care physicians in locations that have been traditionally underserved is essential. Reform does not address how to provide care in traditionally underserved communities and there are no current incentives for existing organizations to develop networks in these communities.

Since it is expensive to develop networks where none currently exists and there is increasing pressure to reduce costs across health care spectrum, there must be—strong disincentives to develop underserved communities. Reform itself must promote the development of physicians to practice in underserved communities.

This could take the form of African-American primary care physician training and other financial incentives to make certain African-American physicians have a significant ongoing role in the future of health care in this country. There is also a need for funds to be made available to promote and assist in the development of physician groups, to assist in the establishment of physician hospital organizations, and joint ventures to the extent of the creation of minority insurance operations.

There are currently nine black-owned HMO's in this country.

African-American physicians could negatively be affected by reform since many do not participate in managed care networks, or have the nominal—or have very nominal participation in networks. This group of physicians have practiced in the Medicaid and Medicare segments where others have refused.

They have been involved in these programs since their inception and have delivered care at substandard fees. Since a significant portion of their revenue depends on these segments, and these providers are not a major—a part of managed care networks, their existence is threatened. Health care reform must include specific incentives to retain African-American physicians that have historically practiced where others have refused. They must not be disenfranchised in the name of reform.

The immediate advantage of this system is to provide a major competitive advantage to the established large carriers. Small niche carriers by definition will be unable to secure quality dis-

counts due to their size. African-American health carriers fit into this category.

These small successful African-American carriers must have the opportunity to compete. There must be provisions and mandates made that they may participate. These provisions could take the form of guaranteed set-asides, financial incentives, or other programs designed to ensure involvement rather than health care reform eliminating the African-American health care companies that have provided jobs in the communities, as well as supplied health care in these communities.

Even though reform might not eliminate the jobs created by these institutions, it would still mean the loss of autonomy if absorbed by large majority firms. Further, the minority providers currently employed by these carriers might have their services jeopardized. The tragedy in these scenarios is that the smaller African-American institutions that have served where no others would could be eliminated.

Thank you.

Mr. TOWNS. Thank you very much for your testimony.

[The prepared statement of Dr. Saffold, and Ms. Brock follow:]

Health Care Reform and Inclusion of the African American Providers

by
Oscar E. Saffold, M.D., President
Leigh Brock, Director of Provider Relations
Personal Physician Care, Inc.
1255 Euclid Avenue, Suite 500
Cleveland, Ohio 44115

Personal Physician Care is a physician sponsored, individual practice association model, regional, health maintenance organization. We are an African American physician owned and operated company serving a ten county area in northeast Ohio. We were formed in 1986 in response to minority physicians in our area who were not allowed access to majority insurance companies. Our physician provider network consists of board certified and board eligible physicians who function as both primary care and specialty providers. The network currently consists of over 600 health care providers dedicated to delivering quality, comprehensive health care. Our challenge is to continue to build a network of providers that will promote, as well as provide, cost effective - quality health care. The key to our successful managed care program is to stress preventive care. Our physicians are obligated to avoid unnecessary and inappropriate care that increases cost, contributing to the national health care dilemma.

Specific incentives to retain African American physicians who are not now a significant part of managed care programs should be developed to train African American primary care physicians in locations that have been traditionally underserved. Reform does not address how to provide care in traditionally underserved communities and there are no current incentives for existing organizations to develop networks in these communities. Quite frankly, since it is expensive to develop networks where none currently exist and there will be increasing pressure to reduce costs across the health care spectrum, there are strong disincentives to developing underserved communities. Thus, reform must itself promote development of physicians to practice in underserved communities. This could take the form of African American primary care training and other financial incentives to make certain African American physicians have a significant ongoing role in the future of health care in this country. There is also need for funds to be made available to promote and assist in the development of physician groups; to assist in the establishment of physician hospital organizations (PHO), and joint ventures to the extent of creation of minority insurance operations. There are currently nine Black owned HMOs in the country.

African American physicians could be negatively affected by reform since many do not participate in managed care networks, or only have nominal participation in such networks. This group of physicians have practiced in the Medicaid and Medicare segments where others have refused. They have been involved in these programs since their inception and have delivered care at substandard fees. Since a significant portion of their revenues depend on those segments and these providers are not a major part of managed care networks, their existence is threatened. Health care reform must include specific incentives to retain African American physicians that have historically practiced where others have refused. They must not be disenfranchised in the name of reform.

The immediate advantage of this system is to provide a major competitive advantage to the established large carriers. Small niche carriers, by definition, will be unable to secure quality discounts due to their size. African American health care carriers fit this category. These small successful African American carriers must have opportunity to compete, there must be provisions to mandate that they participate. These provisions could take the form of guaranteed set asides, financial incentives or other programs designed to insure their involvement.

Health care reform risks eliminating the African American health care companies that have provided jobs in their communities as well as supplied health care in those communities. Even though reform might not eliminate all the jobs created by these institutions, it could still mean the loss of autonomy if absorbed by large majority firms. Further, the minority providers currently employed by these carriers might have their services jeopardized. The tragedy in these scenarios is that the smaller African American institutions that have served where no others would, could be eliminated.

Mr. TOWNS. Ms. Clark.

Ms. CLARK. Mr. Chairman, members of the subcommittee, I am pleased to be here today to discuss the impact of health care reform on minority health care providers. I worked my entire professional career in the managed care arena, and I believe strongly that managed care can improve health care delivery, but only if the managed care plan is run properly.

I am president and CEO of Managed Health Care Systems of New York which is a minority-owned and operated managed care plan. After a 2½-year development period and an investment of more than $12.5 million, we began operations on January 1 of this year in Brooklyn, NY, and we now have over 20,000 members.

What distinguishes MHS from other managed care plans is our social commitment. Our mission is to improve the quality of life of our members by elevating their health care status. We realize that our members' health care needs can't be addressed in a vacuum, and we have to look at all of the factors that affect our health: Low incomes, employment prospects, dependence on transportation, crime-ridden neighborhoods, and the break down of the family. We take all of these factors into account when we design our programs.

The first change MHS is making or trying to make in the lives of our members is to increase their access to primary medical services. Previously the only choices that many of our members had were between an ER room or a Medicaid mill. Now upon joining MHS, a member chooses a doctor for each member of the household from among our group of participating doctors. We are committed to ensuring that neighborhood physicians——

Mr. TOWNS. Just a moment. Evidently we have a problem with our timer because 5 minutes have not passed.

Ms. BROCK. That may have been my red light.

Ms. CLARK. Yes. I think this was her red light.

Mr. TOWNS. She happens to live in my district, so I don't want to cut her off short.

Mr. SCHIFF. Despite the fact that she lives in your district, she is the president of a medical school.

Mr. TOWNS. I am so happy you put it that way.

Ms. CLARK. MHS is committed to ensuring that neighborhood physicians who have traditionally served our members are included in our network, and they are. We recognize the contribution these doctors have made to health care in underserved communities, often struggling for many years against great odds to maintain their practices long after others have left.

We support these physicians, and we are also reaching out to the community health centers to encourage them to work within the managed care environment, since they too are a very integral part of the health service delivery system in our service area.

MHS makes sure that providers participating in its network provide high quality care. Primary care physicians must be available 24 hours a day. If a member's child gets sick in the middle of the night, they have someone that they can call. The providers must also adhere to very stringent quality of care standards and those who don't quickly lose their ability to treat any MHS patients.

Perhaps even more important are our efforts to reach out to the community we serve. MHS doesn't see health care as simply a trip

to the doctor's office, and we realize that in order to achieve real and lasting change, health care and the means for healthy living must be all around us: in the neighborhoods, in the schools, and in our homes.

So for example, MHS operates two mobile health vans that move throughout the north and central Brooklyn service area. Our neighborhood doctors helped us to develop these initiatives and these vans are equipped to provide preventive care and diagnostic screening. They also serve as vehicles for health education. We don't intend for these mobile units to supplant the basic doctor-physician relationship because we encourage our members to see their primary care doctors, but we do realize that many of our members simply are not accustomed to making and keeping doctors appointments. Therefore, these extra steps are needed to make sure that they receive the care that they need.

The Community Moms Program established by MHS is another example of our efforts to bring health care and healthy living to the community. This program trains and employs women in our service area to make home visits to pregnant women and new mothers. The Community Moms will provide parenting training and link women with other needed services such as EPSDT and WIC.

While the list of MHS projects is long, one of the most exciting things about the MHS approach is that it could work in other areas of the country. Strategically, MHS seeks community-based solutions to the health care needs of its members. We build upon the existing strengths of the neighborhoods and we buttress those aspects of the health care delivery system that need our support.

MHS does this in the context of a comprehensive approach to health care, realizing our members' needs are complex and demand these kinds of creative and innovative approaches. Unfortunately, there are several provisions of the bills reported by Senate and House committees that are at odds with the MHS approach and would make it difficult, if not impossible, for our comprehensive community-based approach to managed care to be replicated in other areas of the country. These provisions would also defeat the promise that health care reform holds for economic development in inner-city areas.

Health care reform should not only be a means of rebuilding the health care infrastructure in these communities, but also of providing opportunities to businesses located or willing to locate in the inner-city. There are provisions in the Ways and Means bill, however, which might make it difficult for new minority-owned health care plans to develop. Specifically, I will cite the following three changes which we suggest in the Ways and Means Committee bill: First, regarding financial solvency, solvency standards for health plans should be flexible, permitting arrangements other than equity to protect against insolvency. If equity is the only standard of the adequacy of a plan's solvency, new businesses, particularly minority health care providers who traditionally have limited access to capital, will not be able to enter the field. The health care market would then be dominated by a handful of large public corporations.

Second, regarding assurance of quality in health care plans, we feel that surrogate measures of quality, such as the 50/50 composi-

tion of enrollment in Medicare should be abandoned in favor of objective quality standards. At present, these arbitrary rules discourage development of community-based plans in medically underserved areas where there is simply not enough privately insured individuals to meet the 50-percent requirement. The problem would become even worse of course with the enactment of a Medicare part C program since the number of Medicare enrollees would be doubled or even tripled. Third, regarding ratesetting the rates to be paid to health plans under health care reform should be based on the historical cost of treating the population being served. Inner-city residents, for example, are typically sicker and have higher costs than other populations, so unless the premiums are adequate to serve this population, plans would be deterred from providing care in these communities that need that care.

In addition, plans should receive incentives to provide the health education and outreach services needed to effectively serve medically disadvantaged areas.

Thank you, Mr. Chairman, for this opportunity. I am happy to answer questions.

Mr. TOWNS. Thank you very much, Ms. Clark.

[The prepared statement of Ms. Clark follows:]

KAREN CLARK
President and CEO
MANAGED HEALTHCARE SYSTEMS of NEW YORK, INC.

Mr. Chairman, members of the Subcommittee. I am pleased to be here today to discuss the impact of health care reform on minority health care providers. I would like to begin by describing my company, to give you an idea of the way that managed care in a reformed health care system ought to work. I will then identify for you several issues in the legislation now being considered by Congress that might foreclose opportunities for managed care companies like mine in health care reform.

The MHS Approach to Managed Care

I have worked all of my professional career in the managed care arena. I am a firm believer that managed care can improve health care delivery, if the care is managed properly.

I am now President and CEO of Managed Healthcare Systems of New York, a minority-owned and operated managed care plan. After a two and a half year developmental period and an investment of over 12 and a half million dollars, we began operations on January 1 of this year in Brooklyn, New York, and have over 20,000 members.

What distinguishes MHS from other managed care plans is our social commitment. Our mission is to improve the quality of life of our members by elevating their health status. We realize that our members' health care needs can't be addressed in a vacuum. We have to look at all the factors that affect their health -- low incomes, poor employment prospects, dependence on public transportation, inadequate and often substandard housing, crime-ridden neighborhoods, and a breakdown of the family -- and take them into account when designing our programs.

For example, you can't expect a mother to take her child for his shots and a check-up when the mother doesn't have a telephone, doesn't have the money for the subway, and perhaps doesn't even know how she's going to buy groceries or pay her rent this week. These are the problems that our members face. And they won't be solved just by handing the member a health insurance card.

Primary Care Case Management Increases Access

The first change MHS is trying to make in our members' lives is to increase their access to primary medical care. Before, the only choice for many of our members was between a hospital emergency room or a Medicaid mill. Now, upon joining MHS, a member chooses a doctor for each member of his or her household from among our participating primary care physicians. These doctors, in turn, refer patients as necessary to MHS's

extensive provider network of specialty physicians, hospitals, pharmacies and other medical service providers.

We are committed to ensuring that the neighborhood physicians who have traditionally served our members are included in our network. We recognize the contribution these doctors have made to health care in underserved communities, often struggling against great odds to maintain their practices, and we want to support them.

We also are reaching out to community health centers and other essential community providers in our area. We view these providers as integral to the success of cur plan and hope to establish productive relationships with them.

MHS makes sure that providers participating in its network provide high quality care. Our doctors are board-eligible or board certified, have hospital admitting privileges, and maintain office hours of at least 20 hours per week. In addition, our primary care physicians must be available to their patients on a 24-hour basis. If a member's child gets sick in the middle of the night, that member has someone to call. Providers must also adhere to stringent quality of care standards. Those who don't quickly lose their ability to treat any MHS patients.

To help our members access the health care system, we operate a 24-hour, toll-free member hotline, staffed by MHS staff who speak English and Spanish. Many other plans boast of having 24-hour coverage, but try and call -- you get an answering machine. The MHS hotline answers members' questions and handles their complaints. And it lets them know that someone is always there, and always on their side.

Community Outreach Initiatives

Perhaps even more important are our efforts to reach out to the community we serve. MHS doesn't see health care as simply a trip to the doctor's office. We realize that health care and the means for healthy living have to be all around us -- in the neighborhoods, in the schools, in our homes -- if we are to achieve real and lasting change. Through a number of innovative health education and community outreach programs, MHS empowers its members by giving them the tools they need for a healthy life.

Mobile Health Vans

MHS, for example, operates two mobile health vans that move throughout our service area in North and Central Brooklyn to bring needed health care to the community. These vans are fully equipped to provide adult and pediatric screening for conditions such as high blood pressure, elevated cholesterol, elevated blood sugar, and others. The vans also provide educational programs on management of chronic conditions which occur frequently within the African-American and Latino populations that we serve, such as diabetes, hypertension and asthma. Finally, the vans target critical community needs and promote preventive services such as regular mammograms, pap smears and immunizations.

We don't intend for the MHS Healthvans to supplant the basic doctor/patient relationship -- we encourage our members to see their primary care physicians. But we realize that many of our members simply are not accustomed to making and keeping doctor's appointments, and that extra steps are needed to make sure that they receive the care they need.

Community Moms

The Community Moms Program established by MHS is another example of our efforts to bring health care and healthy living to the community. We are in the process of contracting with the Caribbean Women's Association to train women living in our service area to make home visits to pregnant women and new mothers during their babies' first year and act as case managers.

Under the supervision of professional nurses, the Community Moms provide psychosocial support and parenting training; and help link these women with WIC, EPSDT, and other services to meet their special needs. The Community Moms will also provide counseling and education on topics of great concern to these new mothers, such as HIV, family planning, and coping with the effects of violence in their daily lives.

School-Based Health Care

MHS is also exploring the possibility of starting a school-based health clinic at a school in our service area. The idea behind this clinic would be to reach young people at a critical age, before they start experimenting with risky health behaviors, and help them avoid the all too frequent problems of drug abuse and teenage pregnancy.

Health Education

These and other initiatives are complemented by our regular health education publications. These brochures and newsletters focus on the special health needs of our members, and are written in both Spanish and English.

Strengthening the Infrastructure

MHS is also trying to strengthen the health care infrastructure in the community we serve. For instance, where we see that there is a serious lack of primary care in a particular area, we work to put a practice in place in order to fill that void.

Obstacles to Replicating the MHS Approach in Health Care Reform

While the list of MHS's projects is almost endless, one of the most exciting things about the MHS approach is that it could work in other areas of the country. MHS looks for community-based solutions to the health care needs of its members. It builds upon the existing strengths of its service area and buttresses those aspects of the health care delivery system that need support. MHS does this in the context of a comprehensive approach to health care, realizing that our members' needs are complex and demand creative and innovative responses.

Unfortunately, several provisions of the bills reported by Senate and House Committees are at odds with the MHS approach, and would make it difficult if not impossible for our comprehensive, community-based approach to managed care to be replicated in other areas of the country. MHS has three major concerns with the bills:

1. **Financial Solvency**: Under the Ways and Means bill, health plans would generally be regulated by the states pursuant to federal standards. With respect to financial solvency, the bill would require HHS to follow model standards to be developed by the National Association of Insurance Commissioners (NAIC).

The NAIC should be required to develop flexible standards which take into account the difficulties that start-up and minority-owned businesses may have in obtaining access to capital. Without some provision for protections against insolvency other than equity capital, the health care market risks being dominated by a handful of large insurers, and another opportunity for new businesses, particularly new minority-owned businesses, will be lost.

In addition, current Medicare standards for risk-based HMOs should also be made more flexible. Those standards, too, could discourage new businesses from entering this market because of their heavy emphasis on capital.

Finally, in order to avoid disruption in the marketplace, currently licensed health plans and those in the process of obtaining state licensure on the date of enactment should be given a period of time in which to conform their financial arrangements to the new standards. They should be able to continue to rely for a period of five years on the insolvency standards in effect as of the date of enactment of the bill.

2. Assuring Quality of Care: Under the Ways and Means bill, health maintenance organizations that serve individuals whose premiums are subsidized with public funds must meet the standards currently applicable to HMOs entering into risk contracts with the Medicare program. Among those requirements is the "50/50 composition of enrollment rule" contained in section 1876(f) of the Social Security Act which limits Medicare and Medicaid enrollment to no more than 50% of the plan's total enrollment.

This rule makes it difficult for plans to concentrate on serving the inner city and other medically underserved areas where there are not enough commercial enrollees available to satisfy the non-Medicare/Medicaid enrollment requirement. And unless a plan focuses on those communities, it will not be able to develop the sort of specialized programs that are needed if health reform is truly going to make a difference to our most vulnerable citizens.

The "50/50" rule was originally enacted as a surrogate measure of quality. Given the stringent quality standards contained in the Ways and Means bill, this indirect measure is no longer needed. It should be repealed, and plans should be judged on their performance, not by arbitrary numbers.

3. Rate-Setting for Capitated Plans: In the Ways and Means bill, the amount of the premium subsidy available to a low-income individual would be based on the formula used to develop Medicare capitation payments to HMOs. Because the individuals eligible for subsidies under health reform will have very different medical needs than the elderly who comprise the Medicare population, the data used to develop the Medicare rates may not reflect the cost of caring for persons who are eligible for subsidies. This could deter plans from entering communities with heavy concentrations of individuals who are eligible for subsidies.

Premium subsidies under health reform should be based on the historical cost of serving that population. These data will be available from state Medicaid programs. In addition, the rate should be adjusted further to give plans an incentive to conduct the intensive health education and outreach activities needed to effectively serve this population.

* * * *

Thank you for this opportunity to discuss the impact of health care reform on minority health care providers. Health care reform presents a tremendous opportunity for minority health care providers. At last, there will be a societal commitment to guarantee access to health care for all Americans, particularly those in medically underserved areas.

We must ensure, however, that health care reform does not inadvertently harm the minority health care provider community. Congress must take care not to close this door of opportunity by developing inflexible standards and rules which recognize only one way of doing things and which only work to further strengthen entrenched health care interests.

Mr. TOWNS. Dr. Cortijo.

Dr. CORTIJO. Mr. Chairman, members of the subcommittee, my name is Cortijo. I am the director of the Brooklyn Medical Group, which is one of the six medical groups which constitute the health care delivery system for the Health Insurance Plan of New York, otherwise known as HIP.

HIP is one of the Nation's largest and oldest not-for-profit HMO's founded in 1946 in New York. It is an HMO with health plans operating in New York, New Jersey, and Florida. HIP's combined enrollment at this time in all three regions is approximately 1.2 million voluntarily enrolled persons. Of our 930,000 enrollees in New York, 80,000 are Medicare beneficiaries, over 75,000 are Medicaid recipients, and 3,000 are small employers.

Our membership includes Fortune 500 company employees as well as uninsured individuals of all ethnic backgrounds. In the New York metropolitan area, which obviously includes Brooklyn, Mr. Chairman, your district, we provide, as you very well know, comprehensive health benefits to HIP members in over 50 modern centers.

I personally run two centers in Brooklyn. Several of these centers are located again in medically underserved areas which are identified in my formal testimony. We serve all New Yorkers without regard to race, ethnicity, financial, or health status.

This care is provided by a very large number of minority physicians like me, Chinese, African-Americans, West Indian—doctors of West Indian heritage, East Indian heritage, Asian, Latinos, and Middle-Eastern doctors. This is the HIP mission today, and it has always been our mission. However, our commitment to provide quality care on an equitable basis at this point is being seriously challenged by those established interests that always attacked prepaid health care, namely, the American Medical Association and other medical and medical specialty organizations.

Advocates of any willing provider and essential community provider contracting requirements and mandatory points of service are often those interests with the most to lose from very integrated comprehensive health care delivery systems such as the one that we run.

In recent congressional action, many of these provisions have been adopted in various House and Senate committees, each fundamentally threatens the very existence of HMO's. The 50 million Americans nationally and 4 million of whom reside in New York who have voluntarily chosen HMO's as their provider of choice represent a significant proportion of the population of this country.

If Congress adopts these types of proposals which protect providers rather than the consumers, these will effectively turn the clock back to a time when the inefficiencies of fee-for-service medicine dominated the way in which Americans received and paid for health care.

Congress is debating this issue today precisely because of the explosive nature of the cost of fee-for-service medicine. As a family physician, a primary care physician, a mother and an Hispanic woman, I know firsthand the needs of risk populations, many of whom I serve. I mostly serve African-Americans and Latinos and the frail elderly in the ghetto areas.

I know how difficult it is for people in underserved neighborhoods to get appropriate care without turning to the emergency room to receive any significant preventive health care. This is the environment that these types of proposals, if passed by Congress, will preserve. It will be a sad irony if this were the result of health care reform. Let me be specific.

First, provisions which will permit enrollees, our members, to obtain services outside an HMO's provider network at the discretion of the enrollee without requiring cost-sharing arrangements which encourage the use of the network, this can gut an HMO's ability to operate.

Second, while national health care reform legislation should ensure that individuals do have a choice among competing health plans and among competing types of health plans, HMO's should not be required by law to offer a point of service product in lieu of or in addition to the HMO option.

Third, any willing provider laws which allow providers outside of an HMO's contractor-provided network to serve an HMO's member, restrict any HMO's ability to reach the cost and quality of services provided to its members. One significant result of such laws should be considered by legislators and health policymakers is the elimination of any meaningful collection of data and health outcomes, which is so-called the health report card. Such information is inextricably linked to any competitive model of health system reform.

Mr. Chairman, I thank you very much for this opportunity, and I thank you all.

I am open to any questions.

Mr. TOWNS. Thank you very, very much too, for your testimony.

[The prepared statement of Dr. Cortijo follows:]

My name is Amarilys Cortijo M.D. and I am Medical Director of the Brooklyn Medical Group, one of the six medical groups affiliated with the Health Insurance Plan of Greater New York, a not-for-profit, prepaid group practice model health maintenance organization operating in New York, New Jersey and Florida.

I am pleased to present testimony today that 1) outlines HIP's experience providing integrated, comprehensive health care to inner city residents and at-risk populations; 2) describes how we select physicians to join our medical groups and. 3) addresses some of the important health care reform proposals which would fundamentally restructure the HMO segment of the American health care system, especially the any willing provider and essential community provider proposals.

BACKGROUND

First, let me provide the subcommittee with a brief history of the HIP system. HIP was created during a time of health care crisis in New York City nearly 50 years ago, as a not-for-profit organization with a mission to provide quality, affordable health care to diverse populations.

From its beginning, HIP has offered health care coverage through a community-rating system. This rating treats everyone as part of the same community -- young, old, healthy, sick. It allows varied groups to pay the same price for a wide range of benefits based on the anticipated cost of care for everyone. HIP views community rating as the best way to spread risk while assuring access to health care for all people. We strongly support reform which rely on community rating. Based on the experience in New York state with the recently enacted community rating legislation, it is clear to us that community rating must be combined with universal coverage and other market reforms in order for affordable coverage to become a reality for all groups and individuals.

Today, the HIP system serves nearly 1.2 million HMO members throughout the New York City metropolitan area, New Jersey and Florida. HIP members are employees of groups as diverse as Fortune 500 companies, federal, state and city governments, middle size and small businesses. Others receive benefits through the Medicare and Medicaid programs, and some enroll directly in a special plan for uninsured individuals. HIP also offers coverage to a number of special populations including uninsured children and small businesses enrolled in state subsidized programs in New York. In New Jersey, in addition to enrolling large and small employer groups, and Medicare and Medicaid beneficiaries, we are enrolling uninsured individuals in compliance with that state's recently enacted health insurance reform plan. In Florida HIP participates in the newly established small employer plan. HIP Health Plan of Florida recently entered into a Medicaid contract.

In New York and New Jersey, HIP's prepaid group practice system relies on formal affiliations with groups of physicians devoted on a full-time basis to the care of HIP members. Affiliated physicians practice in medical centers with colleagues from virtually every specialty. Today HIP-New York contracts with six independent medical groups for the services of 618 primary care physicians and 297 specialty physicians. HIP members have access to over 800 consultant specialists on a referral basis. Affiliated physicians care for patients in HIP-owned or leased medical centers. Hospital services of the highest quality available in the metropolitan area are provided through arrangements HIP has with major academic medical centers such as the New York Hospital/Cornell Medical Center, Long

Island Jewish Medical Center, Montefiore Hospital and Medical Center, Albert Einstein and several other leading teaching hospitals.

We have found our prepaid group model system to be highly effective for a variety of reasons. The emphasis on preventive care helps providers detect illness at its initial stages, making early intervention possible and helping to avoid more costly care for advanced illness. Since affiliated physicians devote themselves on a full-time basis to the medical groups and HIP members, they have no financial incentive to provide unnecessary services. At the same time, affiliated physicians are free to order any diagnostic tests they believe are appropriate.

The Congressional Budget Office has recognized the efficiencies of group and staff model HMOs.

> Fully integrated HMOs with their own delivery systems are the forms of managed care for which demonstrated cost savings are the greatest. CBO has estimated that staff- and group-model HMOs reduce personal health expenditures by 15 percent from their levels under traditional private health insurance with typical coinsurance. ("Estimates of Health Care Proposals from the 102nd Congress," Congressional Budget Office, July 1993.)

Further, the CBO has found:

> Moving people from fee-for-service medicine into staff- and group model HMOs would reduce health care spending. If everyone with health insurance were to enroll in these HMOs, national health expenditures could decline by up to 10 percent. ("Managed Competition and Its Potential to Reduce Health Spending," Congressional Budget Office, May 1993.)

Among the reasons for the success of the group practice model is the use of a highly selective provider network that emphasizes the use of credentialed physicians including reliance on primary care physicians who coordinate all a member's care; emphasis on early access and preventive care; and care that is prepaid with limited out-of-pocket payments. Fundamentally, prepaid delivery systems provide for continuity of patient care.

HIP AND INNER CITY, AT-RISK POPULATIONS

HIP is the largest and most experienced provider of prepaid health care to Medicaid recipients in New York State. HIP has served Medicaid recipients since the inception of the Medicaid program in 1966. HIP was the first prepaid health plan in New York State and one of the first in the country to enroll Medicaid recipients. Voluntary Medicaid enrollment now exceeds 75,000.

Medicaid recipients and special populations - - such as those with HIV, the homeless, and individuals coping with drug addiction, many of whom reside in the inner cities where barriers to health care include transportation, poor housing, inadequate schooling and low educational achievement, drug abuse, illegitimacy, and the disturbing results associated with violence, - - present special challenges to a health plan. However, HIP has made great strides to provide integrated health care services in these areas. HIP insists on a one class

system of quality health care that doesn't differentiate among groups or individuals based on their ability to pay or by the source of payment we receive for their care. For example, HIP centers in federally designated medically underserved communities in New York, such as the Bedford- Williamsburg, Lindenwood, downtown Brooklyn (Schermerhorn St.) Manhattan West center at Amsterdam Avenue and 155th Street in Harlem, the Washington Heights center on West 185th Street and Broadway, have a substantial mix of Medicaid as well as commercial HIP members. HIP's one class high quality concept of providing care must be a major component of any health care reform proposal passed by Congress.

Not withstanding HIP's unique experience serving at risk populations, we believe Medicaid recipients, like all Americans, must have the opportunity to choose from among competing health plans. Low income individuals should have the opportunity, like other consumers, to change their health plans if they aren't happy with the care they receive. HIP's experience with Medicaid recipients demonstrates that this approach can be very successful.

By 1990, the escalating cost of New York's Medicaid program, which exceeded $7 billion a year for New York City and $10 billion statewide, set the stage for a major restructuring of health care services delivery to Medicaid recipients. HIP's experience enrolling Medicaid recipients has help smooth this transition. Our Medicaid enrollment as of January 1994 exceeded 76,000, or 8.1% of our total membership in New York. HIP's Medicaid enrollment represents approximately 50% of New York City's Medicaid recipients who receive HMO care. Based on HIP's September 1993 Medicaid enrollment, the State of New York estimated a total federal-state savings of FY 1993-94 of **$17,854,121.**

ENSURING QUALITY AND CONSUMER PROTECTION

Physician Recruitment/Credentialing Criteria

In order to manage care, HMOs must be able to work with providers of the highest quality, and select those which meet the needs of our populations. However, the standards HMOs employ with providers should be documented, reviewed, and actions should not be arbitrary or capricious. Indeed, standards must apply uniformly to all qualified health plans, not just to HMOs as the AMA proposes in the Patient Protection Act suggest.

HMOs support certification of plans by the National Committee for Quality Assurance. In fact, the HMO industry was the first to release a detailed list of health care delivery system standards (Group Health Association of America's "Proposed Standards for Health Plans Under Health Reform"), which reflect not just the industry's own needs, but the state-of-the-art techniques available to plans, providers, and regulators including appropriate quality assurance standards, confidentiality, market conduct requirements, administrative standards, capitalization standards, parental guarantees, protection of consumers in the event of insolvency, and preemption of restrictive state laws.

HIP requires a thorough credentialing review prior to granting a physician status as an HIP affiliated physician. All physicians who treat HIP members, whether belonging to medical groups or mental health centers or functioning as outside consultant specialists, are included in this process. Non-physician providers are also rigorously reviewed and credentialed. Prior to appointment, a thorough review of the qualifications of all applicants

including verification of training (medical school, internships, residencies, fellowships), licensure, board certification, malpractice history and references is conducted. We also use the National Practitioner Data Bank for any additional information on the physician.

All physicians who affiliate with an HIP medical group must, at the time they are appointed, be board certified or board eligible in their specialties. If board eligible, they must become board certified within five years of their appointment. Failure to do so may result in loss of affiliation with HIP.

There is also an ongoing program of recredentialing to ensure that affiliated physicians are reevaluated on a biennial basis. The recertification review includes attestation of current professional credentials, i.e., licensure, medical board status, hospital affiliations, review of malpractice actions, a check for disciplinary action by professional affiliations, and assurance of acceptable annual performance review. In addition, biennial inquiries are made of the National Practitioner Data Bank.

All appointments of physicians who treat HIP members, whether affiliated with medical groups or functioning as outside consultant specialists, are subject to the approval of the Medical Control Board. The Medical Control Board is composed of approximately 20 members, approximately half from HIP and half from teaching institutions in the New York metropolitan area.

HIP has a long history of equal opportunity employment practices as well as a non-discriminatory system of enrolling members and providing medical care which predates any legislation requiring us to do so. Indeed, today HIP exceeds compliance with all Federal, State and local anti-discrimination laws with regards to patients, providers, support personnel and vendors. HIP does not collect or maintain system-wide ethnic data on the medical groups with which it contracts as that data is not required for its internal purposes or by its regulatory and supervisory agencies. Recently HIP responded to an inquiry from the National Medical Association explaining that ethnic data on enrollees and providers associated with HIP are not collected.

Peer Review/Credentialing Activities

The six HIP Medical Groups conduct an annual review of all approved physicians. The annual credentialing audit is conducted in the following manner:

1. Upon hiring a new physician, temporary approval is requested from the Medical Control Board at HIP until the next Medical Control Board meeting is held.
2. The following documents should be submitted to the Medical Control Board at least one month in advance of the regularly scheduled meeting:
    a. The completed Physician's Application Form;
    b. The Medical Control Board Physician Approval Form;
    c. Supporting documents, as specified about the Physician.
3. The Medical Control Board sends in the request to the National Practitioner Data Bank for any information on the physician.
4. The completed Physician's Application Form, with supporting documents, are forwarded to the HIP Research & Statistics Department. The physician is assigned a unique number and information on the physician is entered into the computer file.
5. When a physician is approved conditionally or with certain waivers, it is the Regional Medical Group's responsibility to see that these requirements are met.

6. When a physician is not approved by the Medical Control Board, the Medical Group shall not continue to use his/her services to care for HIP enrolles.

Termination Of Physicians

It is logical that not every physician will be professionally satisfied in the group practice setting and, therefore, we have a two year interval before the new physician is eligible for partnership status in the medical groups. That interval has proven adequate for the group and the physician to mutually determine whether the collegial setting of a closed panel group of physicians, working together under the same roof, sharing medical records, serving together on committees and referring patients to each other meets both the needs of the physicians, the group and the patients. Neither race, gender, nor age are criteria for asking a physician to leave our groups. We think that any final reform bill should require all health plans to have stated, objective criteria for employing and terminating physicians. In addition, we support the anti-discrimination provisions in the House versions of health reform; however, we think those provisions should be made stronger by requiring appropriate reporting requirements to monitor that neither physicians, other health care providers, employees nor patients are discriminated against in employment or when seeking health care.

LEGISLATIVE PROPOSALS

Preserve Essential Community Providers But Limit Mandatory Contracting

Proposals to preserve and develop community-based providers for medically underserved populations should be supported. Such proposals should include appropriate nondiscrimination standards, general and special access standards, and reporting requirements that would include key indicators of access, quality, and service. Where health plans fail to meet such requirements, plans should be required to contract with certain, appropriate and truly community-based providers.

Such a standard was endorsed in a recent report released by the Congressional Black Caucus entitled, "African American Community Requirements of Health Care Reform" which stated:

> It is mandatory that any health reform legislation must include a provision that requires health plans serving either medically underserved or health professional shortage areas ... to contract with "essential community providers" or demonstrate that they can provide the same health care delivery system that would be provided by the essential community providers.

Further, if there is mandatory contracting we believe that these contracts should only be entered into with an appropriate mix of organized, primary care providers during a defined transition period. In addition, we support the Finance Committee requirement that during the five year transition, the Secretary could set standards for the designation of additional essential providers if the Secretary determines that the health plans would not otherwise be able to assure adequate access to benefits covered in the standard benefit package. The Finance Committee added a requirement for terms and conditions for

contracts with essential providers which treat the provider on terms at least as favorable as those applicable to other participating providers for the scope of services and the basis for payment. HIP supports that provision. We think that contracts between health plans and federally qualified health centers (FQHCs) and non-profit rural health clinics would be an appropriate legislative provision during this transition period. Mandatory contracting requirements with a broader list of "essential community providers" would not be in the best interests of patients or the public health in our service area. In Brooklyn, for example, we have several health centers located nearby or very close to many "essential providers" (see display). Mandatory contracting would: destroy the concept of a unified patient medical record where all procedures, prescriptions and treatment recommendations are maintained; result in duplication of scarce primary care resources in underserved areas; prevent evaluating quality assurance and outcome studies of patient care; and, would increase the costs of health care.

CONCLUSION

Almost fifty million Americans and four million New York state residents have voluntarily chosen HMOs. Their satisfaction with these plans, according to recent surveys, is higher than those in fee-for-service. That satisfaction is due, at least in part, to the high quality of care HMOs deliver at a cost which is considerably less than they would otherwise pay .

The key ingredient to retaining satisfied members is the physician-patient relationship. Health plans such as HIP -- with a highly diverse racial and ethnic membership, e.g., African-Americans, Caucasians, Hispanics and Asians, Haitians, Russian Jews, West Indians and many others -- can not satisfy their members unless they are committed to serving all populations on a non-discriminatory basis with physicians and other health care personnel who are culturally sensitive to the different needs of our diverse groups.

> Last week the New York Times editorial "The Failed House Health Bill" described "detrimental features of the leadership bill...for example require[ing] most plans to hire any qualified doctors who apply - thereby eliminating the plan's ability to control the quality and cost of treatment by closely supervising a small panel of doctors."

"Meat axe" approaches to public policy which mandates HMOs to contract with certain individual or institutional providers, when our medical group already has those services available and accessible to all members, does little more than duplicate scarce primary care services in medically underserved areas and fragment health care into categorical segments. Instead, health reform should encourge the integration of all populations into a multi-speciality health plan where all services all available under one roof.

Thank you for inviting me to participate in this hearing and I would be pleased to answer any questions.

Mr. TOWNS. Dr. Oden.

Mr. ODEN. Thank you, Mr. Chairman. I, along with Mr. Jim Turner, will present our testimony together, and so in terms of the tyranny of the light, if you just understand there will be one voice, but to extend the green light twice, we would appreciate that. With your permission——

Mr. TOWNS. Let me put it this way: You have 5 minutes and Mr. Turner has 5 minutes.

Mr. ODEN. And he is yielding his 5 minutes to me.

Mr. TOWNS. So have you 10 minutes?

Mr. ODEN. That is what I am asking, sir. Thank you. We would like to present the written testimony fully for the record.

Mr. TOWNS. Without objection, your entire testimony will be included in the record, of all of the witnesses.

Mr. ODEN. Thank you. We join the other witnesses in thanking you so much for showing the leadership on this particular very important subject matter.

The issue of the survival of minority providers, and even the larger issue of the survival of the minority community in health reform is something that must be looked at just very seriously, and too often has not been given full and complete airing.

We would also just like to acknowledge Congressman Stokes and the leadership that he has shown through the Health Trust of the Congressional Black Caucus and the leadership over the years that he has presented to us.

Mr. Turner and I, the reason why we can make our testimony together is that even though he is from Ohio and I am from Los Angeles, we have the same backgrounds. We started at community health centers, started in communities where the very poor and the very sick are found, started with organizations that were partial responses to our government's trying to address the question: How can you empower local communities and provide health services where there really isn't any?

But as a result of our involvement in our local communities and looking at all of the options that were available, we both saw that the issue of prepaid health services, particularly operating as an HMO, turned out to be the most efficient and effective way of addressing the needs of our respective communities. We are nonprofit organizations; we are consumer-run organizations; and we are organizations that have at the very heart of our operation the needs of responding to the needs of our community.

But in doing that, we now know several things, and we would like to share them with you. First of all, that in terms of our respective experiences, in Ohio currently total—health care plan in Ohio has about 25,000 members, serving about 100,000 persons overall. In Los Angeles, the Watts Health Foundation and our HMO United Health Plan serves a total of about 200,000 individuals, about 100,000 of them are in our HMO.

We have particular focus on low-income communities, on persons that have been disadvantaged, and we have tried to do what conventional wisdom said could not be done: Operate in a prepaid environment using Medicaid dollars as essentially the resource. We have now been able to show over the years of experience that it can be done; it can be done effectively and efficiently, and health care

reform, with respect to minority providers, as far as we are concerned, ought to be reasons to jump for joy.

The reason for that is that what health care reform purports to bring first of all is comprehensive health services to populations that oftentimes still basically are uncovered in terms of care, and that is important. Second, what it does is it encourages the use of the model that we now know works very well for this population in terms of HMO type services.

Our concerns are that in trying to implement health reform, that we don't—and trying to solve some of the problems that have long existed in minority and low-income communities, and trying to address the concerns, rightful concerns of minority providers, we don't break the system that we are trying to in fact enhance.

And there are several areas where we think this system could be broken. You have heard some of the testimony earlier; let me underscore a couple of those points, as well as to suggest some things that will, we think, help solve some of the problems that are being faced.

First of all, things that will burden us in trying to address the needs of our community are provisions that are being called any willing provider. This is not just a minority issue; it is a much larger issue than that. We are held accountable for what we do. Unlike insurance companies where if an unfortunate outcome occurs, the insurance company is then looked at for why did that happen; it is between the provider and that particular patient.

In the case of HMO systems, we are intimately involved in whatever outcome occurs. We have to be able to be assured that the providers that are part of our system are people that we believe can best carry out the mission of the organization. No more than anyone would pick a lawyer out of a phone book and just assume because he or she happened to have passed the bar that they can effectively represent an individual's particular needs, the same thing is true in health care. There are criterias, some objectives, some not as objective in terms of understanding who can best work in terms of the mission of our companies. We believe that any willing provider presents an opportunity to make our organizations not work very well.

The second issue is around the issue of essential community providers. Our organization is based upon every single discussion really qualify the essential community providers. However, we know that in order for us to survive, it is not a matter of just being entitled, we have to perform. It is not enough just to say that because we are from a particular class of providers; therefore, it ought to be followed that we participate. We have to prove our worth. We have to prove it to our consumers; we have to prove it to the consumers; we have to prove it to everybody in the system.

If there is a group of providers who have been told that they are entitled and don't have to perform, what we do is to invite mediocrity, and there is a concern there. On the other hand, managed care organizations must demonstrate that they can serve communities that are greatly underserved, and in many instances they are going to have to use, and they must use, and they should use, organizations such as community health centers and rural health centers, and many minority physicians and physicians who are multi-

cultural and competent in materials of speaking various languages and understanding cultures. However, at the same time, what brought health reform to the fore in the first place is the challenge of providing cost-effective, high-quality care, and those principles must always be adhered to.

Third and fourth, points that are also important is that in many local locales, the preemption of State—in some locales, State antimanaged care laws are a concern to us, and we think that federally that there ought to be a preemption of such antimanaged care laws.

And fifth, we are concerned about the collusion on the part of some providers in terms of having antitrust provisions weakened. But let me suggest to you that we think can help solve many of the problems that we think are facing our community and providers within our communities.

First, there ought to be strong antidiscrimination laws so that any institution that discriminates on the part of gender or race or any of the other protected categories, that they pay the price for that. Discrimination on that basis is not only un-American, but needs to be clearly said to be illegal, and any institution doing that ought to be punished.

Second, that there ought to be provisions to encourage the building of new state-of-the-art medical facilities in medically underserved areas. Redlining is in fact a reality. Many providers cannot build the kinds of facilities in order to fully participate with managed care organizations, because banks will not loan, insurance companies will not insure those kinds of construction.

In health reform legislation, there needs to be provisions so that physicians and other providers going into medically underserved areas can build the kind of spacious, state-of-the-art facilities that the communities deserve.

Third, we believe that minority and other urban medical schools such as represented earlier by Dr. Sullivan and Dr. Tuckson, ought to, in fact, receive funds in order to help train and retrain minority physicians so that they can more effectively compete in the new managed care environment.

Yes, in fact, there is some catchup that has to go on in terms of minority physicians being able to better participate in managed care. Part of that has come as a result of the fact that many minority physicians ignored the handwriting on the wall, that managed care was going to be coming and instead continued to hang on to fee-for-service far too long. We now need to level the playing field, and we think by empowering those institutions that have special relationships with minority providers that we will be able to shorten that period of time.

Mr. Chairman, I have much more in the written testimony, but I just want to say that we think that the subject is very important. We really congratulate you for giving us the opportunity to present. But be very careful that as we try and address problems that have been societal for some time, that we don't in fact throw out the baby with the bath water.

Thank you so very much.

Mr. TOWNS. Thank you. Let me thank all of you for your testimony.

[The prepared statement of Mr. Oden, Jr. follows:]

THE IMPACT OF HEALTH REFORM ON MINORITY PROVIDERS

Presented by: Dr. Clyde W. Oden, Jr.,
President, Chief Executive Officer
Watts Health Foundation, Inc.
United Health Plan

EXECUTIVE SUMMARY

The Watts Health Foundation, Inc. is one of the largest minority managed community-based health systems in the United States. For more than 27 years it has been a pioneer not only in the area of providing health services to low income and minority communities but also as a large socially responsible HMO serving Southern California. It serves more that 200,000 patients annually and currently has nearly 100,000 members in its HMO. It is one the largest employers of minority providers and has one of the nations largest networks of ethnically diverse providers in its managed care network.

MAJOR POINTS

- Health care reform that provides for universal coverage and comprehensive benefits and consumer choice will be a major positive event in the lives of minority providers. The threat of minority providers is limited to their failure to organize themselves and prepare to fully participate in the reformed health system.

- The most significant reason why minority providers have not been more involved in managed care has been their own resistance to give up their love affair with old-fashioned fee-for- service reimbursements and their failure to change their practice patterns to conform the requirements of the new and emerging health care systems.

- Health reform, as proposed, works best with providers that are organized in either a group practice model, a staff model, or a modified Independent Practice Association (IPA). Solo practicing, independent offices are inefficient and not compatible with the modern system of health care delivery.

- Health Reform provides at least three significant benefits to all Americans, especially minority communities:

  1. Best models of health care practices, which promote high quality, low cost care.

  2. Comprehensive benefits with a focus on prevention, and early diagnostic services.

  3. Economic and Community Development in communities that have suffered significant disinvestments.

- The major threats to health reform that will not help minority providers and will threaten the benefits desired in a reformed system:

  a) Any willing provider
  b) Essential community provider
  c) Lack of preemption of state anti-managed care laws
  d) Weaking of anti-trust provisions

- Major improvements to the health reform legislation that will positively impact minority providers:

  a) Strong anti-discrimination laws.
  b) Provisions to encourage the building of new state-of-the-art medical facilities in medically underserved areas.
  c) Grants to minority and urban medical schools to train minority physicians on how to prosper in a managed care environment.

THE IMPACT OF HEALTH REFORM ON MINORITY PROVIDERS

Mr. Chairman, the Honorable Edolphus "Ed" Towns, and members of the subcommittee on Human Resources and Intergovernmental Relations, I am Dr. Clyde W. Oden, Jr., President and Chief Executive Officer of the Watts Health Foundation, Inc. and its Health Maintenance Organization: United Health Plan. I have served in this capacity for 15 years, and have worked for the corporation for the last 25 years.

The Watts Health Foundation started as a Neighborhood Health Center after the Watts Revolt in 1965 as one of the health care demonstration projects of the Office of Economic Opportunity, and has been serving communities in Southern California since 1967. Our mission as a non-profit community based health organization includes serving low income and medically underserved populations, medically indigent infants, adults and senior citizens, and being a catalyst for economic, social and political empowerment in communities that have been disadvantaged.

We have been true to our mission, and over the last several years we have grown significantly in the pursuit of making a difference in the communities we serve. We currently serve more than 200,000 persons annually including more than 100,000 in our federally qualified Health Maintenance Organization, known as United Health Plan. We also operate two community health centers including the Watts Health Center and the United Health Plan MedCenter in Compton, California. Our delivery systems include a very large substance abuse program, geriatric programs, school-based health centers, mobile medical centers, and outreach and treatment programs for HIV infected persons. With nearly 1000 employees and an annual budget that exceeds $225,000,000, we are not only the largest private minority employer in the Western United States, we are one of the largest minority managed private community-based health systems in the country.

The current enrollment mix at United Health Plan is about 65% medicaid, 15% medicare, and 20% commercial members.

Our health system includes more than 60 full time employed physicians, as well as dentists, optometrists, pharmacists, and other health professionals including more than 100 nursing personnel. We contract through United Health Plan with more than 2500 physicians, dentists, and health professionals and with more than 100 hospitals, nursing homes, home health agencies, and other providers. We have the largest group of ethnically diverse providers found anywhere including significant numbers of African Americans, Latino Americans, Korean Americans, Chinese Americans, Vietnamese Americans, and Anglo Americans. Our patient population is as diverse as the population of Southern California, with no racial or ethnic group comprising more than 40% of our population.

The experience we have gained in the last 27 years serving such diverse populations, I believe, makes us uniquely qualified to present testimony on the possible impact of health reform on minority providers.

On a personal note, my professional involvement in health care reform should be of some interest to you. Early in the development of the Health Care Reform Task Force of the White House, I served as an outside consultant, and presently I serve as a member of the Board of Directors of the Group Health Association of America, the California Association of Health Maintenance Organizations, the National Association of Urban-based Health Maintenance Organizations, the Western Association of Community Health Centers and I am an ex-officio Board member of the Charles R. Drew Medical Society. My testimony, however, represents my personal perspective based on 25 years of direct and relevant experience in attempting to provide high quality health care services in some of the most challenging environments in the United States.

The goal of health reform, as articulated by the President of the United States and the leadership of both the United States Senate and the House of Representatives should cause minority providers to jump for joy. A system of health care that offers universal coverage with comprehensive private health insurance, giving the CONSUMER CHOICE regarding the system of care he/she will be a part of, will empower minority providers in a manner unprecedented in United States history. The challenge for the minority provider community is preparing for these new opportunities.

In reality, if the consumer is free to choose, and if minority provider continues to earn the respect and confidence of the people who have traditionally HAD to use them, then health reform will be as significant to minority providers in the next century as the existence of the traditionally Black medical schools have been to African American physicians in this century. Furthermore, historically the minority physician has been burdened with the problem of serving a community in which many of their patients could not pay for the needed services, and thus they were 'penalized' economically for serving their community. Guaranteed coverage will mean that minority providers will not have to shoulder the burden of uncompensated care. In my judgment the problem of health reform as it pertains to MOST minority providers isn't reform itself, but rather the question will revolve around minority providers preparing themselves for the technological and systematic requirements that are established in the NEW health care arena.

I have been an unabashed supporter for prepaid health services for 20 years. I have spoken in dozens of national meetings including meetings of the National Medical Association, the Golden State Medical Association, the National Association of Community Health Centers, and Group Health Association of America, in which I have stated unequivocally that managed health care is not only the wave of the future, but is the BEST system of health care for communities that have been economically and socially, and medically underserviced. Often, especially prior to 1992, my advocacy has been ignored. In fact at one meeting of the

National Medical Association, I gave a speech in which I likened myself to Noah, saying its "going to rain", and that the only safety for minority providers was in banding together in group practices and affiliating with HMOs. I was roundly booed, by a group of Black physicians who insisted that HMOs would never survive and that the fee-for-service practice of reimbursement was NEVER going to disappear. That speech was given more than 15 years ago, and in case anyone has missed the weather report: Its raining very hard, with no let up in sight! The medical practice predicated upon fee for service as the generator of significant revenue for most physicians is becoming extinct.....and good riddance. It is very clear that the reason that good comprehensive health care is not available today to millions of Americans is because of the escalating cost caused by the old fashioned fee-for-service reimbursement system.

My observation about the preparedness of many minority physicians for reform is not without great sympathy. I WANT MINORITY PROVIDERS, especially primary care physicians and practitioners that practice in medically underserved areas, to not only survive, but to thrive. I believe that our minority communities can be saved from further financial devastation and deterioration IF the third largest industrial sector in our country, health care industry, is effectively organized in these communities. On the other hand, I have no sympathy for those who would like to either freeze the practice of health care in the inefficiencies that currently exist, or to deprive the communities that I know best of the BEST PRACTICES, AND BEST TECHNOLOGIES, AND BEST MODES OF PRACTICE that have now evolved in this country.

The advantages that health reform brings to minority communities and to minority providers are several:

1. **Prepaid health services.**

   Whether the mode of practice is in the GROUP PRACTICE MODEL, STAFF MODEL, or modified INDEPENDENT PRACTICE ASSOCIATION MODEL, organized patterns of practice where the incentives for long term success of the system are based on providing timely preventive, early diagnostic, and primary treatment at the community level, is the best technology available for treating any community, but especially those communities devastated by poverty, drugs, crime, and low incomes. It takes a team of dedicated providers serving a defined population to make a difference. Health reform promises this.

   The best models of practice in this environment are well-managed community based health centers [staff models], or physician owned group practices, or IPA practices that are co-located in a few dedicated suites of offices. Competition for health care dollars will reward systems of care that are efficient, have LOW administrative costs, are technology dependent, and are organized so that duplication of services is eliminated, and coverage of comprehensive services occurs AT THE COMMUNITY LEVEL.

2. Patients with private health insurance with comprehensive benefits.

Often minority providers today have to make compromises on the best means to treat their patients because the patient has inadequate resources to pay for the most appropriate care. Health reform as advocated by President Clinton, and by the House and Senate leadership IS comprehensive. What is especially important is the availability of covered preventive health services, primary health care and prescription drugs. These are essential elements for any quality health care program. Currently many minority physicians, especially those who must depend upon the outrageously low payments from fee-for-service Medicaid programs, often can't provide these services in a timely and effective manner.

Under health reform, especially in a system of health care modeled after federally qualified Health Maintenance Organizations, such care is encouraged, covered, and practiced. A minority provider under health reform, as currently anticipated, will be able to provide to his/her patient these essential services without compromise.

3. Economic and Community Development

Often overlooked and ignored by minority health care providers, not fully appreciated by policy makers is the tremendous potential for reinvestment in local communities as a result of health care reform, especially as proposed by the President and Congressional leadership. The math is simple. Multiply the revenue per head for every legal resident living in a Congressional district. If the average number of citizens is 500,000 as an example, and if the expected cost per enrollee in a health plan is $1500 annually, the amount of dollars in each Congressional district for health care is $750,000,000. Typically 40% of that revenue is for outpatient care, which is $300,000,000. If the providers in any Congressional district organized themselves into EFFICIENT delivery systems, which could be new primary care centers, much of those revenues could be captured and kept within the district. This could mean more jobs, and in turn more secondary industries, and more economic and community development.

PLEASE NOTE: THIS CANNOT HAPPEN WHEN PROVIDERS ARE ENCOURAGED TO PRACTICE IN THE OUTDATED, ANTIQUATED SOLO PRACTICE MODEL. THAT MODEL CANNOT FINANCE THE DEVELOPMENT OF THE INFRASTRUCTURE NEEDED TO ATTRACT ENOUGH PATIENTS AND CAPTURE THE REVENUE THAT CREATES COMMUNITY DEVELOPMENT. ADDITIONALLY THE OUTDATED FEE-FOR-SERVICE PRACTICE MODEL IS ANTITHETICAL TO COMMUNITY DEVELOPMENT.

In conclusion, health reform offers unparalleled promise to those minority providers who have a vision of the new paradigm of health care delivery. Health reform as

currently advocated presents an opportunity for the practice of better health care, it offers better benefits for the consumer, and it offers perhaps the last great opportunity for economic and community development in communities that badly need such a boost.

ATTACHMENT

RESPONSE TO QUESTIONS ASKED BY THE CHAIRMAN:

1. "Your personal concerns regarding the proposed health care reform legislation and your opinions as to how they can affect minority providers."

I have several major concerns about some of the proposals being considered as part of health care reform. The following provisions currently exist in the Democratic Leadership's Proposal in the House of Representatives, and if not, changed could destroy the benefits of reform that I had previously outlined:

a) **ANY WILLING PROVIDER.**

The major reason why Health Maintenance Organizations have enjoyed the confidence and success they have achieved over the last 21 years, is that it has been an ACCOUNTABLE health system.

Insurance companies, generally are NOT held accountable for the providers they pay for. The assumption is that the patient picked the doctor, and if the doctor is bad, or the outcome undesired, it is the doctor's fault, not the insurance company, as long as it paid timely for the services in its contract. Not so for HMOs.

We are responsible, and rightly so, for the care received in our system.....we are accountable. Therefore, we have the responsibility of approving or NOT approving every provider. We know it takes more than just a license and an office to practice medicine. We compete for the loyalty of our members, and we should be held publicly accountable for the health of our members. THIS IS NOT POSSIBLE UNDER THE PROVISIONS OF "ANY WILLING PROVIDER" PROPOSALS.

The surest way to break a system that is working is to mandate ANY class of providers in a managed care system. The thought is antithetical to how HMOs work. This is the equivalent of requiring an employer to hire "any willing and every willing worker". It is just a very bad idea.

Finally, in the minds of some minority providers, this abhorrent proposal, ANY WILLING PROVIDER, offers some protection for them. An effort to include minority providers through a provision like this will surely fail. The only providers that will benefit under such a provision are lawyers who will be paid by both providers and HMOs to litigate every discharge from a system, and every denial into a system.

b) ESSENTIAL COMMUNITY PROVIDER

The focus should be on the populations to be served, and not protecting any class of providers. HMOs and other systems that would be the beneficiary of health care reform should be held accountable for demonstrating how they can effectively serve every identifiable population group in its service area. There should be access standards, and quality standards, and standards related to language proficiency and handicap accessibility. In many instances the only way those standards can be met is by using the types of providers that are seeking special status, such as community health centers, rural health centers, and academic medical centers. However, as in the case of ANY WILLING PROVIDER, HMOs must be held accountable for the delivery of the services. If any group of providers become ENTITLED, because of who they are, rather that what they are doing, and how well they are doing it, it is a formula for mediocrity.

In the original House Ways and Means Committee legislation, there was even a proposal to include as "essential" any provider who has a practice that is open at least 20 hours a week in a medically underserved area. I personally know of physicians that qualify under that definition in whom I could NEVER send any patient to, nor could I be held accountable for their practice. Their facilities are filthy, their practices border on pushing drugs, and I am certain their practice fails to pass the "mother test". The "mother test" is: would you send your own mother to that office for health care. The same is true for some providers in every classification that is seeking to be ENTITLED. Not every health center, nor every family planning center, nor every academic health center would pass the "mother test".

c) PREEMPTION OF STATE ANTI-MANAGED CARE LAWS.

A national program of health reform must have national standards. There are already numerous examples of how special interesst can influence a single state's legislative process and enact legislation that is designed specifically to injure Health Maintenance Organizations and managed care providers. Federal legislation must preempt local efforts to change managed care.

d) ANTITRUST

There are efforts to include in health care reform provisions that would weaken antitrust laws with respect to unlawful collusion by health care professionals. Currently lobbyists for some national physician groups under the guise of "patient protection" are seeking to allow physicians to price fix. This movement is clearly not in the interest of consumers or health reform.

2. "What protection for minority providers, in your opinion, should be included in the health reform bill?"

a) **ANTI-DISCRIMINATION PROVISIONS**

The number one protection should be a strong anti-discrimination provision in the law. No system of care, whether it be HMOs or insurance should be allowed to discriminate against a person on the basis of race, creed, color, religion, national origin, gender, and the other protected classes that are now found in federal law. There should be strong federal fines and penalties for any organization found guilty of such discrimination.

These provisions, of course, will not protect incompetent providers, or those that fail to meet objective standards. Such requirements such as "Board certification" or "Board eligibility" are NOT discriminatory, although it may have as an unintended consequence eliminating a disproportionately high number of minority providers.

b) **PROMOTION OF INVESTMENTS IN MEDICALLY UNDERSERVED COMMUNITIES.**

Minority providers need to be encouraged to organize themselves into efficient economic units, and build group practice sites in medically underserved communities. What is needed is government backed loans for infrastructure development in the purchase of land, buildings and equipment, and insurance coverage for the newly developed businesses. REDLINING is a reality, and there has been STRUCTURAL discouragement of reinvesting in low income communities. Legislation is needed to direct financial resources to medically underserved areas for infrastructure development.

The construction of new, spacious, state of the art medical facilities, that are accessible to the community will provide employment, create secondary level jobs, and create momentum for the redevelopment of many communities.

c) **PROMOTION OF THE CONCEPTS OF MANAGED CARE AMONG MINORITY PROVIDERS.**

The four historically Black medical schools and other major urban academic medical centers should receive grants for both the training and the retraining of physicians and other providers in the concepts of managed care. The reality is that there is catch up that must occur. For too long, too many minority physicians worshiped at the altar of fee for service, and they are not prepared for the current revolution in health care practices. An example of a collaboration that is going on is the MANAGED CARE COLLEGE that is being developed jointly by the Watts Health Foundation and the

Charles R. Drew University of Medicine and Science. In the Fall, 1994, the first class of physicians will be invited to learn how to survive in this new environment.

d) DON'T GIVE MINORITY PROVIDERS A FALSE SENSE OF SECURITY

Any effort to dull the pains of change in the minority provider community will do the intended recipient a major disservice. Health reform DID NOT start in Washington, and is not a political phenomenon. The solution, in terms of greater minority provider involvement, is not in making them a "protected class". Health reform is about change. The change is on the level of economics, quality care, administration, patient care, community responsibility, and technology. If minority physicians are sheltered from this changing environment by being told, in essence, you don't have to change, MANY WILL NOT CHANGE AND WILL FALL FURTHER BEHIND.

Health reform, under the most optimistic scenario, will not be in place for another 3-5 years. Any group of providers that cannot change, adjust, and operate to the emerging and known standards of the health care industry with that kind of EARLY WARNING is too far embedded in the' sand of denial' to protect! I am convinced that most minority physicians will be able to adjust to the changes required to be competitive in this new environment.

3. "Personal encounter with discriminatory practices when dealing with health maintenance organizations or any other health care related organizations."

In more than 21 years of involvement in the HMO industry I have personally experienced several kinds of discriminatory practices. They fall in the following categories:

a) Government sanctioned discrimination.

Under existing public law there is a presumption that any organization like the Watts Health Foundation, Inc. and its HMO the United Health Plan is INFERIOR to "commercial HMOs" merely on the basis of having too many Medicaid and Medicare members in our plan. This bias evidenced itself 18 years ago when we first applied for the status of being a federally qualified HMO. We were told by government officials that the HMO Act was for commercial plans, and that a plan that had a disproportionate number of medicaid members, COULD NOT get the government's highest seal of approval. The so called "50-50" provision which restricted membership of a plan to no more than 50% of its enrollment, except by specific WAIVER, is evidence of this bias. It is assumed that Medicaid beneficiaries cannot discern for themselves what "quality health care" is all about, and a prepaid provider that serves their community is automatically suspected of being of poor quality.

THIS FORM OF DISCRIMINATION STILL EXISTS. IT IS OUR DESIRE TO SEE PUBLIC POLICY CHANGED SO THAT THIS STRUCTURALLY BIASED VIEWPOINT DISAPPEARS FROM THE PUBLIC STAGE. ALL HEALTH PLANS SHOULD BE HELD TO THE SAME STANDARDS AND MUST DEMONSTRATE THAT THEY PROVIDE HIGH QUALITY, CULTURALLY SENSITIVE, COST EFFECTIVE HEALTH CARE----AND THE CONSUMER MUST HAVE THE ABILITY TO CHOOSE THEIR PLAN BASED ON ANY PUBLISHED STANDARDS THAT TAKE INTO ACCOUNT RISK ADJUSTED FACTORS THAT REFLECT THE ENROLLEES SERVED.

b) Provider discrimination against health plans that serve low income populations.

Early in our development as an HMO we found many of the major medical groups and hospitals were reluctant to contract with our Plan because of our member mix----too many Medicaid patients. These same providers did not want to acknowledge that these government supported patients were underfunded and expected to be paid disproportionately high rates to serve this population. It took provider education, and an opportunity for our organization to prove itself before we could get many of the major providers to contract with us. Today, I can happily report that we have a waiting list of 70 medical groups and at least 20 hospitals that badly desire to contract with United Health Plan, because they now know how important it is to be able to serve all parts of the community.

c) Minority provider discrimination against HMOs.

One of the most disturbing developments in our 21 year history was the antipathy that minority providers, especially African Americans, had against HMOs. We had major challenges trying to get minority physicians to contract with our plan, and to organize their practices so that they could QUALIFY to be part of our system of care. Too many minority physicians for too long would not accept the concept of capitated prepayment. We had to develop a system of care that bypassed this antiquated thinking.

Although today some of our most financially successful contractors are minority, [if we use as a criterion receiving more than $1,000,000 in annual capitation payments successful], many of those physicians were ostracized by their colleagues for being involved with our HMO.

NOW, HOWEVER, THE PENDULUM HAS SWUNG THE OTHER WAY AND SOME MINORITY PHYSICIANS WANT TO BE MANDATED INTO HMO SYSTEMS. THE PERSPECTIVE OF THESE PROVIDERS IS TOO CENTERED

ON SELF-INTEREST AND NOT ON CHANGING THEIR PRACTICE PATTERNS TO MAKE THEM ATTRACTIVE TO HMO SYSTEMS OF CARE.

PREPAID MANAGED CARE IS A SYSTEM OF PRACTICE THAT DEMANDS HIGH QUALITY, PATIENT-CENTERED, POPULATION ORIENTED, TECHNOLOGY- DEPENDENT ORIENTATION. IT IS MORE THAN MERELY A CONTRACT--IT IS A NEW MODE OF PRACTICE, SIGNIFICANTLY DIFFERENT FROM THE OLD STYLE FEE FOR SERVICE, PIECEMEAL APPROACH. THOSE PHYSICIANS AND OTHER PROVIDERS WHO NEED TO BE PART OF THIS NEW PARADIGM, MUST CHANGE THEIR ORIENTATION. THAT IS WHY WE ARE IMPLEMENTING A MANAGED CARE COLLEGE IN LOS ANGELES TO MAKE THIS POINT.

d) Lack of understanding of managed care by the U. S. Public Health Service, and the National Association of Community Health Centers.

Federally qualified health centers, community health centers and rural health centers have been systematically discouraged from being involved in risk-based contracting with HMOs. As a result we have an expectation by health center advocates that their organizations ought to be involved in managed care, but, under THEIR conditions, and not that which the marketplace dictates. Community Health Centers and rural health centers are valuable providers in our health care system. Many of these organizations provide high quality, cost effective, and culturally sensitive health services to underserved populations and underserved communities. They can prosper in a managed care environment, provided they accept the proposition that they must compete with other provider organizations for the loyalty and support of their patients. An expectation that they would be paid on a COST BASIS, and not accept financial responsibility for the professional components of heath care delivery will only retard their development. As a result, health centers are being discouraged from being full participants in the emerging forms of health care delivery....namely risk-based capitation. Everyone should have to operate by the same set of rules, and be paid equally and fairly.

4. "Adjustments that you had to make due to increased efforts in your area to form managed care organizations."

We had to create our HMO when their was active hostility toward having an organization that had as its primary target low-income communities. Today the environment has changed. There are nearly two dozen HMOs actively competing against each other for market share, and the adjustments we have to make focus on becoming MORE cost effective; providing even HIGHER quality services; providing

MORE value to our current and potential members; using MORE technology to better serve our members, to REDUCE ADMINISTRATIVE OVERHEAD, and to meet the increasing demands of the purchasers and the regulators of HMO services.

This increased focus on performance and expectation for continuing improvement of our health system is a challenge we gladly seek to meet. We have seen HMOs truly become the vehicle for health reform that improves the lives of the populations we have a concern for: the poor, the elderly, the infirm, the disadvantaged. We are concerned that efforts to change HMOs to accommodate those elements unwilling or unable to change, will inevitably harm the best vehicle for implementing health care reform to benefit 100% of the American public.

Mr. TOWNS. Let me just request a couple of questions——

Mr. SCHIFF. Mr. Chairman, excuse me. Before you begin questioning, I just have to say for the record and to the witnesses that Mr. Portman and I have a meeting scheduled at 11:30 that we are going to have to go to in a little bit, and I just want to point out to the—as I said earlier, being a little late, it is at a stage in Congress where a number of things are happening at once.

We have a meeting dealing with the proposed legislation. I just want the witnesses here who have testified and witnesses who are coming after them to understand that although they may see Members of Congress going in and out of hearing rooms, everything is being recorded over on the side there and it is made available to all Members of the Congress in due course.

So that is the purpose of the hearing, and the information is taken down regardless of how many Members are able to be sitting at the platform at any one time.

Thank you, Mr. Chairman.

Mr. TOWNS. Thank you. And also I agree with the fact that you know, generally—you are generally here, and so I understand that sometimes these conflicts do come up.

Mr. SCHIFF. Well, fortunately we have a guest sitting on your side, Mr. Chairman, or we would outnumber you again.

Mr. TOWNS. Well, I am certain that my side will read the testimony, no question about it.

Let me just begin by saying that I think it was you, Dr. Brock, you stressed the fact that all of the physicians were board certified.

Ms. BROCK. Or all board eligible.

Mr. TOWNS. Yes. Recognizing the fact that there is a group of physicians out there that have been providing care for quite some time, and in many instances quality care, and now at the age of 55, 60, and 57, 58, and all of those kind of years, but are not board certified, and at this point and stage in their life, they probably will not go back to become board certified. They have had no problems, no malpractice problems or anything of that nature.

What should we do with those physicians? Should we just leave them alone and say goodbye, you have provided 30 years of good service and good for you, or how should we deal with that?

Ms. BROCK. As mentioned earlier, we do publish our criteria to any interested providers so that they know specifically what the credentials are that we are looking for. We do have some providers who can demonstrate through experience that they are quality physicians and they can treat our patients, and our board has the latitude to make some exceptions.

One of the things that Personal Physician Care does is also, along with the education of those providers in managed care, is to try to facilitate these providers in bringing in newer providers into their system since they are at an age where they might be seriously considering leaving the medical practice, leaving a large medical practice to get additional providers in with them so that they could still continue to participate in the managed care programs.

So we do have some exceptions which we would grandfather in, but that is by board exception. So we do have a little latitude as far as our credentialing policy, but again, it is by exceptions.

Mr. TOWNS. Let me ask you all very quickly. Do you feel that we should have some grandfather and a grandmothering—I don't want to leave anybody out.

Mr. ODEN. Mr. Towns, if I might respond, in Los Angeles Drew University and the Watts Health Foundation, my organizations have come together to create what we call a managed care college, in which we are in fact providing an opportunity for those physicians that have not understood or have not been involved in managed care to really come back on board, so that they can participate.

The problem with any grandparenting activity is that on one hand, there is a need for us to publish criteria. The more exceptions you make, the wider the net, and the more problems that I think we all inadvertently create. I know that is not what is being attempted here, but in fact, that is what will occur.

The challenges are that there is a demand on the part of the consumers that they want the best performing health plans, and, in fact, all the talk about report cards we think are very wonderful. But when systems are in fact being held publicly accountable on one hand, we can't be held at the same time saying keep your door open to practically anybody who comes through on the other, because they happen to have been around.

And so you are raising a very tough question. But when it seems like as we move toward any willing provider status, what we are going to do is create full employment for attorneys, because we are going to—there is going to be an awful lot of litigation whenever a decision is made to exclude or include, and I don't think we want to spend our health dollar in the area of litigation.

Dr. CHOW. Mr. Chairman, if I could give a different perspective. I think we have great concern, not about publishing criteria; let me say that personally, and our plan would fully agree that criteria should be published and physicians or other providers should not be lacking in their ability to understand those criteria and also appeal egregious discharges, et cetera.

Our concern is that within at least our population, many of the current providers are people who have come from overseas, whose talents we are able to use, because we don't have Laos or Cambodia or as many Vietnamese trained physicians as we might need in order to deliver the care that these people can understand.

Many of these are well-trained physicians in other countries that have been granted licenses here. In our own population, we have the very same problem that you just alluded to, that we would have to either grandfather, if you want to put it that way; if we were using a board certification as a standard, we believe that the tyranny of the board certification then allows the board itself to make sort of the judgments about who should practice.

We would prefer to consider that board certification and/or experience comparable and therefore a track record even of how well a provider carries out his care is perhaps even more important, and we would prefer to see that that type of option would be available. That type of option is available in the State of California title 22 laws that govern the type of physician supervision of hospital services. For example, a chief of medicine must be available who has board qualifications from an American board or its equivalency.

We believe that the real issue is how one carries out those duties and at what level, and therefore, we would opt for not a severe criteria—certainly not a national mandate that, as an HMO standard, if there were to be such standards, that board certification be required, because we believe that we would exclude many, many well-qualified and culturally sensitive providers.

Ms. CLARK. MHS would also pretty much support that position. We would definitely want to retain the ability for some kind of a peer review process, because we also look at doctors, especially primary care physicians, based on how long they have been working in our communities.

There are also other ways that you could get at monitoring quality. So certainly for these physicians, we might do a stepped-up medical audit review or do it more or sooner or taking them first or whatever. We also would offer additional training that is not always available to these doctors. But they do meet all of the other criterias, and we would strongly urge that we be able to keep that peer review process, to be able to permit these doctors to continue giving care.

Mr. TOWNS. All right. At this time, I yield to Congressman Stokes.

Mr. STOKES. Thank you, Mr. Chairman. Let me commend each of the panelists here for the excellent testimony that you have given us, and testimony which I think will be very helpful in terms of the issues that we are concerned with. I want particularly to welcome Dr. Brock and Jim Turner, my fellow Ohioans here today.

Let me ask you this: A number of States, including of course Ohio, which is my own State, have applied to the Department of Health and Human Services for waivers in order to be able to implement statewide Medicaid managed care programs.

I would be interested in knowing how would these waivers affect the quality of health care provided to the African-American or other minority community, and will these services be reduced or expanded through these waivers, and how should quality of care be assured if these waivers are granted?

Are you familiar with what I am asking about?

Dr. CHOW. Yes.

Mr. TURNER. Mr. Towns and Mr. Stokes, the State of Ohio currently has in a request for an 11:15 waiver. We have looked at what would be the impact of it upon us as minority HMO's and providers.

I think that the point that was made earlier on by some members of the panel such as a strong antidiscrimination language being in there is not protectionist, but to make sure that we don't exclude those individuals who have been providing the care to that particular market.

The second part of that is there is a need to credential, and I support the idea of the ongoing retraining so that providers can participate in the continuum care. That is part of the reasons why the criteria that most HMO's have in place about credentialing is to ensure that their providers can have privileges at hospitals, because they are confronted with that, in order to ensure their members that the continuum of care will be continued by their current provider, is that that provider must have access to a hospital, and

that hospital, part of the requirement of getting privileges to hospitals is that they meet certain criteria.

The other thing that I would like to say about that, though, is that I really think that there should be—there is a need to have in those waivers some relief for those to ensure that those providers who have been serving the population can continue to do so. Because I think otherwise, the experience is that those who have not served this population see this as a golden opportunity of it becoming their cash cow for a number of reasons.

Some of them have to do with the location of the facilities, so access is not available. And part of monitoring the quality will ensure that access is available within a reasonable amount of time.

Dr. CHOW. Mr. Stokes, if I might also respond.

Mr. STOKES. Sure, Mr. Chow.

Dr. CHOW. From my experience, I do sit on the Multi-Cultural Task Force which is advisory to the Secretary of Health in the State of California. We have dealt with your question from a minority level, and I am hoping that experience would be helpful to you.

Mr. STOKES. Sure.

Dr. CHOW. Which is that one, the State of California has mandated that any of the providers, be they—well, first the State of California, as you know, in several experiments, but the one that is in 13 major counties will be selecting one mainstream HMO, and then a county local HMO that can be developed through all providers who wish to join a county HMO to offer a double option to the medicaid recipient.

However, all HMO's, including the mainstream HMO, must meet certain standards of cultural competency. A cultural competent standard was drawn up and has been tentatively agreed to by the Department of Health, which then would ask that—and I placed in the testimony a definition of what that is, so I won't take that time up. But those would be the parameters.

Now, how to measure that is what they are now struggling with, and which we ourselves, with another Latino HMO is trying to help validate. But this I think then achieves that: First, traditional providers in the law must be allowed access into the systems. They have to come under the same rules and guidelines and have the same quality, but they are allowed, and that access must be available.

And second, which I would also commend to the House and the government is that cultural sensitivity standards be established so that those issues that we have all spoken about are going to be addressed which means that each mainstream provider must then demonstrate if they are going into a marketplace that has a significant number of minority providers that they can provide those services, or they will obtain panels of people who can.

And I will be happy to provide more information.

Mr. STOKES. Anyone else want to comment?

Dr. CORTIJO. Yes. Just to give you a slight different view on this, New York at this point in time is operating its Medicaid managed care program under the Federal waiver. HIP, the company that I work in, enrolls 76,000 Medicaid recipients, which has produced significant cost savings to the State and Federal Government,

while at the same time increasing access to quality comprehensive care.

In my written testimony I do address that, how we have been able to cut down on the escalating cost of providing health care by enrolling the Medicaid patients or recipients through a managed care approach.

Mr. STOKES. OK. Dr. Oden.

Mr. ODEN. Finally, I think it is an excellent question that you ask because of the amount of attention that is being given to 11:15 waivers. What we think the major advantage is is is that providing HMO-type services to a population that right now is really behind the curve rather than in front of the curve. The Medicaid populations in our judgment has been severely disadvantaged by the old fashioned fee-for-service system, and so the 11:15 waivers will allow various States to accelerate, moving into managed care.

What California is doing is very instructive. That is, setting up criteria that requires managed care organizations to demonstrate that they can address the needs of local patient populations, and I think that that is most important.

The burden must be on us to show, to demonstrate that we can, and in every instance what that means is that there is new kinds of relationships that are being established in local communities.

Dr. CORTIJO. If I may add just one more thing. The beauty of enrolling the Medicaid patients and the Medicare patients under the managed care umbrella is that a patient is a patient is a patient. I don't know what label the patient has; the patient walks through the door, the patient is a sick person; you do not look at what kind of label or plan they are coming from; you treat them all the same.

Mr. STOKES. That basically is why I wanted to get to that question, because naturally we are concerned that persons who are dependent upon Medicare be given the same type of care anyone else would get, and we don't want this distinction of class or condition to be a precedent to one's care.

Thank you very much. Thank you, Mr. Chairman.

Mr. TOWNS. All right. Thank you very much too for your questions. You know, I must say that there is a lot of things going on in that area; I guess some of you might be familiar with Ten Care, which is in Tennessee, and there seems to be some information coming out of that. You know, I guess we sort of have to follow it a little closer to see how it is working.

I was just sort of thinking, that I think—my problem when you get a waiver like that for a State, that you are sometimes forcing physicians in that might not want to be in, and that sometimes can create a problem. So I think it is just something that we might need to look at as well, because if you have the doctors not wanting to be in and you are saying you have to be in, I think that sometimes that could affect care.

Dr. CORTIJO. But if I may reply to that, how does the doctor in a managed care setting that I work in, we do not know who is Medicaid and who is not medicated.

Mr. TOWNS. But this is a state. What happens is that in Tennessee, that it was not the State legislature, it was that after getting a waiver, it was that by executive order of the Governor, who indicated this is what is going to happen, and that, you know, even

after the AMA and everybody said that we don't want it to happen, I think that every doctor in the State voted against it, but still, the Governor says that without the State legislature, he says, this is what is going to happen. You see, that is different from what is happening in New York.

You are talking about in terms of the whole State, and this is the name of the game. And I am saying that that is something——

Dr. CORTIJO. But I still think, I still think that even if it was mandated, as you are saying happened in Tennessee, if you are one person, sole practitioner, fee-for service, you have more tendency not to take that Medicaid recipient that pays you only $1, that if you work in a managed care setting with 30 other doctors and you don't have time, or that is not your job to look at people's insurance.

Your job in managed care is to be a physician. Therefore, the insurance is dealt with somewhere else behind doors and the physician does only medicine. So my distinction is in fee-for-service versus managed care, we do not—the impact of who is paying is not as significant in the day-to-day life of the doctor.

Dr. CHOW. If I may, Mr. Towns, I am not that well acquainted with the Ten Care, but that sounds like the waiver may have a problem. In California, I might say, that with this opportunity to look at different ways of structuring payment, I believe that at least in our county in San Francisco, we are going to enhance the ability for Medicare recipients today now to receive care because with the fee-for-service, very low reimbursement, we were losing practitioners who were willing to accept them.

We are getting much more response now to the fact that we might in fact have a city-wide IPA that has spread out the risk, working to try to be more efficient, and also be able to deliver the care, and I think we have.

We are going to probably have more providers, now, Sacramento seems to have more than they ever had. So I think it would be a matter of how that waiver was granted. And I think your concern is very real, and therefore, how the administration, the granting waivers and the Congress needs to be very concerned that access is available for the physicians too to be able to participate.

Ms. CLARK. I agree that under a mandated situation access becomes an area of very high sensitivity and HCFA begins to feel that it has to monitor that very closely, which means inclusion pretty much of any willing provider under a any that meet the credentialing criteria, and I do agree with you that in those situations, every provider servicing the mandated area is going to feel necessarily, from a pure business standpoint, especially institutions, that they must join whether they have that commitment or not. And I think that the concern would be to be careful that you don't see separate Medicaid facilities developing within organizations, because that is something that has occurred.

Mr. ODEN. Just one final point. For those physicians that would rather not participate in managed care environment, in every other segment of our industry, whether it is of the commercial segment, the marketplace is moving everyone toward managed care.

And Medicaid really can't be a shelter there either. The important thing is to make certain that the patients are taken care of,

and that there are standards to protect the patients so that issues of access and cultural competency are addressed.

Mr. TOWNS. Well, let me thank all of you for your testimony. You have been extremely helpful in so many ways. Thank you very, very much.

Dr. CHOW. Thank you.

Ms. CLARK. Thank you.

Mr. ODEN. Thank you.

Mr. TOWNS. At this time we will call our next panel. Dr. Arindell, Dr. Rodney Ellis, Dr. Evans, Dr. Fobbs, and Dr. Watson.

Let me begin by first welcoming you and to say to you that your entire statement will be included in the record, every I, every period, every comma will be included in the record. If you will just summarize your statement within five minutes which will allow the panel to raise questions with you.

Why don't we start with you Dr. Arindell.

STATEMENTS OF DR. DEBORAH ARINDELL, ANESTHESIOLOGIST; DR. SHAWNE BRYANT, GYNECOLOGIST; DR. RODNEY ELLIS, GENERAL INTERNIST; DR. THERMAN EVANS, CARDIOLOGIST; DR. DENARD M. FOBBS, OBSTETRICIAN/GYNECOLOGIST, PRESIDENT-ELECT, GOLDEN STATE MEDICAL ASSOCIATION, NATIONAL MEDICAL ASSOCIATION; AND HERMAN WATSON, GENERAL SURGEON

Dr. ARINDELL. Good morning, Mr. Chairman, and members of the subcommittee. My name is Dr. Arindell. I was formerly employed by Kaiser Permanente as an anesthesiologist from August 1989 until December 1992, at which time I was terminated.

Prior to that time, I had an evaluation which was written in June, which was not discussed with me by my immediate supervisor, and at no time was any indication given that there was any problems with my clinical performance.

Subsequently, I was put on administrative leave in October 1992, and subsequently in December 1992 was terminated because Kaiser Permanente decided that I needed to leave and seek academic retraining, although there was never any documentation in any of my clinical evaluations that I had any difficulties with any major problems with giving anesthesia.

In addition, I subsequently found employment at an institution where I had trained at, and a letter was sent from Kaiser Permanente's law firm which shed negative light on me and my new employment.

Basically I am here to have the subcommittee understand that that a very serious issue is going on in terms of HMO's and how minority physicians are treated in terms of hiring and firing practices, especially when it comes to due process or lack of due process.

In my case, at no time was I given any notice, any fair hearing or any opportunity to hear any of the information which was decided upon on the action that was taken on me. My evaluation, which was clearly signed by my immediate supervisor and her immediate supervisor, the only comment, negative comment that was on there was that difficult intubation which there had been a cull of difficult intubations that were challenged, but at no time was

there any indication that I was going to be asked to leave Kaiser Permanente and seek academic retraining.

It is just an issue, and it is a pattern that I have seen, it is my personal belief that it is a pattern, particularly among HMO's and particularly affecting minority physicians, that when it comes to hiring and firing and disciplinary actions, we are not given due process.

In addition, these—it is very important that this issue be addressed, because the employment—this type of employment information travels with you from job to job. Obviously when I had to go to my new job, I had to tell them—give them the reason why I had left Kaiser Permanente, and upon giving that information, when they tried to acquire information from Kaiser Permanente, they received a very discriminatory letter from their attorneys.

I personally know of several other physicians who currently work for Kaiser Permanente, or have worked for Kaiser Permanente who have been in the same situation that I have been in, that have been unfairly discriminated against, denied their practices, denied their shares and subsequently terminated.

The issue that I see that this subcommittee should address basically is that if this country is going to move toward managed health care and the majority of black physicians are going to be working in managed health care, then some mechanism needs to be in place whereby these HMO organizations should be held accountable for the number of physicians, especially minority physicians that are hired, the number of minority physicians that are fired or terminated and the reasons why.

In addition, some mechanism should be put into place whereby these HMO's should be monitored in terms of how they deal with disciplinary actions against especially minority physician and how it affects their careers later on.

My own situation, I was fortunate enough to be able to go back to the institution from which I had trained, but other physicians are not able to do—to take the path that I am taking and there are a lot of physicians out there whose basically careers are being destroyed because working in some of these HMO's, they are being subjected to discriminatory practices in terms of having their practices monitored.

There are some surgeons that now are working that have to have other surgeons come in and watch them, stand over them. Their practices are being monitored in terms of how many cases bad outcomes come, whereas this is not happening to other nonminority physicians in—within the same organization.

So basically, my issue is that if we are going to go toward the managed health care and HMO's are going to be the wave of the future, then mechanisms need to be in place whereby these HMO's are not allowed to discriminate against minority physicians.

Thank you.

[The prepared statement of Dr. Arindell follows:]

August 4,1994

I was employed by Capital Area Permanente Medical Group-Kaiser Permanente, (CAPMG)as a staff anesthesiologist ,from July 17,1989 up until December 1,1992 at which time I was terminated . Prior to working for Kaiser I had completed a residency in anesthesiology at the Johns Hopkins Medical Center. During Desert Storm I spent almost five months on active duty in Germany as part of the Army Reserve and returned to full time work at Kaiser in May of 1991. In June of 1992 I received my annual evaluation which was signed by my immediate supervisor, a physician , also an anesthesiologist and the Physician In Chief of the Kensington Medical Center, a physician in internal medicine. The evaluation forms at Kaiser are two pages in length. There are several categories to check off including one for clinical skills. The ratings are satisfactory, unsatisfactory and needs improvement. In addition, there is a space for written comments. My immediate supervisor checked off clinical skills satisfactory and wrote under the comments section that "difficult intubations continue to be a challenge". At no time did my immediate supervisor discuss the evaluation with me nor discuss with me the fact that both she and the Physician in Chief of the Kensington Center would go before the CAMPG board on September 15,1992 and recommend that the my third share be denied/deferred. At that meeting my immediate supervisor told the board that I had some difficult intubations and that I had not be amenable to counseling or supervision. At no time had my immediate supervisor even come into the operating room and watch me perform intubations, epidurals or spinals as part of a evaluation process and give me feedback or make comments concerning my clinical skills. I did in fact see the Physician in Chief to discuss my evaluation sometime either in July or August of 1992 discuss the evaluation as part of CAPMG's routine practice. At that meeting

the Physician in Chief did not inform me that I would not be receiving my third share nor did he inform me that I would be asked to leave Kaiser for poor performance. I had expected to receive my third share in August of 1992. When I returned from vacation in September I noted that my name had not been included in the list of physicians granted shares in September 1992. I called the Physician in Chief who was on vacation and subsequently called my immediate supervisor to inquire why I had not received my shares. My immediate supervisor met with me on September 30, 1992,in the cafeteria of the Holy Cross Hospital at a lunch table with another physician present. At that meeting, my supervisor informed me that I had not received my shares because I had trouble with intubations and (epidurals and spinals which she had forgotten to write on my evaluation). My supervisor informed me that I needed to leave Kaiser and seek academic retraining. My supervisor told me that the time that I spent on Active Duty in Desert Storm had not been beneficial to me. On the following Wednesday, I went to speak to the Physician in Chief of the Kensington Center about the matter. At that meeting I told him that I wanted him to speak to other physicians in my anesthesia group and the surgery group concerning my clinical skills. I was asked what I would do if talking to my colleagues was not helpful. At no time did the Physician in Chief meet with me again with regards to the request I had made of him. At that point in time, when my supervisor informed me that I needed to leave my job and seek academic retraining it was a Monday and she wanted my decision by that Friday. There is a fact finding committee at Kaiser to which you can appeal to for help but they take a period of time to investigate and I did not have that kind of time. On Thursday I retained an attorney to represent me. I made it clear to the officials at Kaiser that I would not leave my job and seek academic retraining because I did not need it and as a matter of principle my due process rights had been violated. There was no documentation by my supervisor that I had poor clinical skills. It must be noted that for a physician to leave

his or her job and seek academic retraining is something of a precedent given the fact that at the time I was a board certified anesthesiologist. It must be noted that during this time I continued to take call at the hospital by myself without any supervision even thought my supervisor and the CAPMG board had decided that my clinical skills were allegedly so poor that I needed to leave and seek academic retraining. How could one be such a poor clinician yet continue to be put on the call schedule, put in the position of performing intubations, epidurals and spinals on patients during the months of July, August, September and October of 1992, even though the CAPMG had voted in September to deny my third share and request that I leave Kaiser and seek academic training despite a June 1992 evaluation which stated that my clinical skills were satisfactory. It cannot be both that my clinical skills were so inadequate that I needed to leave Kaiser and at the same time still take call at night and perform procedures without supervision. I subsequently had my attorneys forward to Kaiser a statement on my behalf of why I was not leaving to seek academic retraining. Kaiser never returned a formal letter of acknowledgment to my attorneys. Sometime in October I received a letter from the Secretary of the CAPMG informing me that I was on a two week administrative leave and during that time I was to come up with my own " monitoring plan". I subsequently wrote to the board and informed them that I was not leaving Kaiser to seek academic retraining because it was not warranted. Please note that at no time since my initial meeting with my supervisor on September 30, 1992 had I been presented with an list of specific incidents of which I had allegedly rendered inadequate medical care to patients. To this day neither the first attorney nor has my current attorney received a list of specific patient names, charts and documentation of my alleged inadequate provision of medical care. On November 30, 1992 I returned to the Kensington Center where I met my immediate supervisor who informed me that she had personally called John Hopkins Medical Center, Department

of Anesthesiology and informed them I needed to return for academic retraining. This was done without my permission and as you could imagine was done with the intent to embarrass and ridicule me. Also at that time my supervisor told me that I would no longer be administering anesthesia to patients but only doing preoperative evaluations. I asked my supervisor to put this in writing as I considered this a change in my clinical privileges, but she told me that she did not have a typewriter. I informed her that I would not even consider this arrangement until I saw it in writing (I did not consider this an option but I wanted it in writing for my records). I went downtown to Kaiser offices and spoke with an attorney for Kaiser who stated that the letter would be coming from California to the effect that I could only work in the preoperative area. Needless to say that I never received any letter from the California office stating that. At that meeting my supervisor informed me that if I did not accept this reduction in clinical privileges that I could be reported to the Maryland Board of Physician Quality Assurance. I considered this not to be an option in my best interest and a threat. In addition, while downtown trying to obtain a copy of the alleged letter from California, I attempted to speak with the Medical Director of the Board of CAPMG. He initially was in when I arrived but I was later informed that he had left for the day and when I attempted to meet with him later in the week, I was told that he would be unavailable for the whole week. I later received a letter from the Medical Director of the Board of CAMPG informing me that if I did not accept my immediate supervisor's plan for my clinical duties and return to Hopkins, by December 2 or 3 of 1992 I would be terminated. I did not accept this proposal since it was not in my best interest and I did not feel that I needed academic retraining. Also, the Medical Director of CAMPG sent me a letter stating that he had, (dated November 25, 1992), personally reviewed the charts of the patients to whom I had allegedly rendered inadequate care and he agreed with my supervisor that I needed academic retraining. To my knowledge the

chairman of the Board of CAPMG is a internist and not an anesthesiologist. I was subsequently able to obtain employment at the Johns Hopkins Bayview Medical Center. However, in response to a letter sent by my current employer, the law firm which was retained by Kaiser, on behalf of Kaiser ,retaliated against me by forwarding a letter which stated false information and was intended to shed a negative light on me. It has been two years since I have been in litigation with Kaiser,and in the process have spent about twenty thousand dollars in attorney's fees. I currently have filed a Title VII discrimination lawsuit against Kaiser.

I have experienced first hand the pain of what can happen when an African-American's medical career is destroyed by a large and powerful organization such as Kaiser Permanente. Many nights I lie awake and feel like I am David trying to fight Goliath in attempting to battle Kaiser to clear my name. As a physician, what has happened to me at Kaiser will follow me from job to job. Kaiser Permanente should not be allowed,nor any other health maintenance organization be allowed, to terminate African-American physicians or deny them their shares without due process. As this country moves toward a managed health care system, individual practicing physicians will probably become a thing of the past. The majority of minority physicians will be working for health maintenance organizations. There needs to be a method of ensuring that physicians, but especially minority physicians ,will be represented in health maintenance organization not only at the primary physician levels but in managerial positions as well. However, what is most important is that there be some mechanism to ensure that minority physicians will have due process when it comes to issues concerning their competency, hiring , disciplinary actions and termination. If there is no one overseeing this process then what has happened to me is going to be repeated over and over again. As long as organizations like Kaiser feel that they do not have to answer to anyone when it comes to due process and employment issues, then

the outcome is bleak for minority physicians in health maintenance organizations.

Deborah J. Arrindell M.D.
1407 Bermuda Dunes Ct
Mitchellville ,MD 20721

Mr. TOWNS. Thank you very, very much for your testimony. Mr. Ellis.

Dr. ELLIS. Good morning, Congressman Towns, and other members of the subcommittee, thank you for your interest in this matter and for the opportunity to express my views on health care reform.

I am Dr. Rodney Ellis. I practice general internal medicine here in Washington, DC, and as a solo practitioner, I am told by many that I am, a dying breed. Hence, I appreciate the opportunity to explain from my perspective this process of extinction and will do so by generally addressing the specific questions regarding personal experiences that you pose in your invitation for me to testify.

I will start by saying that I have a long history of concerns about the direction of health care reform. After 4 years of undergrad work at Howard, 5 years of med school at Stanford and research there as well, and 2 years of residency at Johns Hopkins Hospital, I changed direction in 1977 to a course of general internal medicine from academic medicine. The country seemed to me then and now to need more primary care practitioners and African-Americans especially. I chose to go directly into a health maintenance organization, HMO, which seemed the wave of the future with the apparent ability of employed physicians to simply practice medicine and not worry about collecting bills and the theoretical economic orientation toward preventive health that those HMO's afforded.

Well, I became disillusioned with that HMO whereas the doctors had become unionized, had two strikes in 8 years. To cut costs, the administration decided to put a quota—an actual number limit on the ability of primary care physicians to refer to specialists outside the HMO for tests or procedures on patients not available inside the HMO. I said I would quit that HMO if they did it. They did it and I quit. That organization essentially went bankrupt thereafter and I have since gone into private practice. Because of my very genuine interest in our profession, I have served as president of the D.C. Society of Internal Medicine and am currently the vice president of the Medical Society of D.C.

I say there are two lessons learned from this personal odyssey. First, HMO's are not a panacea in health care reform, especially if the physicians who are truly the managers of the organization's resources are adversaries of the administration. Physician leadership and input is integral to any health care organization.

Second, the corporate financial bottom line can sometimes conflict with principles of good quality care; therefore, safeguards must be put into health care legislation so that full disclosure is given to consumers as to what sort of constraints and enhancements are directed toward their physicians. This matter is well outlined in the Patient Protection Act, which has been introduced into this very Congress and is included in my testimony.

Further, this issue of blunt efforts of cost savings has implications for the questions you asked regarding discrimination against and protective measures for minority providers. In managed care entities, where the physician contracts to see patients in his or her own office, it is now very commonplace for these organizations to track with computers the use of the resources by those physicians. It has been very well documented in the last few days in Amy

Goldstein's series here in the Post on the inequities of health care in this metropolitan area that physicians who care for older, sicker, and predominantly nonwhite populations may use more resources in that care. Those physicians should not be penalized in that regard because corporate financial decisions to bluntly cut such providers out is harmful to minority patients and their physicians. We at MSDC have entered in fact into a legal action against a local insurer, Blue Cross/Blue Shield of the National Capital Area over its use of a computer program which Blue Cross used as a basis for decisions about which doctors to invite to participate in an insurance plan for Federal employees. As far as we can tell, the decisions are based on doctors' use of resources. We believe that this computer-based selection process has not been verified by chart review or outcome research. And providers who are qualified and capable, who happen to care for sicker patients, must be protected from this sort of thing.

I also am in favor of the provision promoted by the Congressman from Georgia, Mr. Lewis, John Lewis on the essential community providers provision that was discussed earlier by other witnesses. The NMA has made clear recommendations in this regard and I have included that information as well in the appendix.

Now, with regards to your question in terms of my changes in my own private practice, I have indeed witnessed major changes in the 7 years—since I left the HMO—in my private practice. It has been a progression in which I have seen a majority of my revenue shift from fee-for-service category to those with the income from three managed care entities with which I participate. There is an associated substantial increase in the administrative burdens with regard to gatekeeper functions, preauthorization, more paperwork and the like, and this is all for a discounted fee. It is here that one can see the workings of a dying breed phenomenon: Primary care private practitioners are drowning in overhead to now collect a discounted fee from these networks. We are going out of business.

We must keep the model that we have available to us and I have a few suggestions in that regard: That we have a universal claim form, that we have a standard benefits package of covered services that all of us can understand and we reduce this unnecessary buildup of middle management.

I haven't given any attention in my testimony—you didn't ask for it—with regards to malpractice suit tort reform, but I can't overemphasize the importance not only to the majority community, but the minority community in regards to health care reform that we have malpractice tort reform.

Thank you for the time.

[The prepared statement of Dr. Ellis follows:]

Testimony of Rodney Ellis, MD, General Internist in Washington, DC

to the

Human Resources and Intergovernmental Relations Subcommittee

of the House Government Operations Committee

Congress of the United States

Chairman, Edolphus Towns

Hearings on "The Impact of Health Care Reform on Minority Providers"

Friday, August 5, 1994

Good Morning Congressman Towns and other members of the Subcommittee. Thank you for your interest in this matter and the opportunity to express my views on healthcare reform. I am Dr. Rodney Ellis. I practice primary care general internal medicine here in Washington, DC. As a solo practitioner, I am told by many that I am a "dying breed." Hence, I appreciate the opportunity to explain, from my own perspective, this process of extinction and will do so by generally addressing the questions you posed in your invitation to me to testify. First, you asked for my personal concerns regarding health care reform and its effects on minority providers; next, what protections for minority providers should be included in the healthcare reform bill; thirdly, any personal encounters I may have had with discriminatory practices by managed care entities; and finally, what are the adjustments I have had to make as a result of managed care influences.

I will start by stating that I have a long history of concerns about the direction of health care reform. After four years of undergraduate work at Howard University, five years of medical school and research at Stanford University, and two years of residency at Johns Hopkins Hospital, I changed direction in 1977 from a course in academic medicine to training in primary care general internal medicine. It had

become clear to me that I most enjoyed the continuity of care with patients in outpatient settings and that the country in general, and black people specifically, needed more primary care practitioners. I chose to go directly into a health maintenance organization (HMO), which seemed the way of the future with the apparent ability of employed physicians to simply practice medicine and not worry about collecting bills, and the theoretical economic orientation toward preventive health.

Well, I became disillusioned with that HMO, wherein the doctors had become unionized, and had two strikes against management within 8 years. To cut costs, the administration decided to put a quota -- an actual number limit -- on the ability of primary care physicians to refer to specialists outside the HMO for tests or procedures on patients not available inside the HMO. I said I would quit the HMO if they carried out that policy; they did and I quit. That organization essentially went bankrupt and I have since gone into private practice. Because of my genuine interest in our profession, I have served as President of the DC Society of Internal Medicine and currently, I am Vice President of the Medical Society of DC.

I would say there are two lessons learned by this personal odyssey. First, HMOs are not a panacea in health care reform, especially if the physicians -- who are truly the managers of the organization's resources -- sit on the other side of a bargaining table in a union-management relationship. Physician leadership and input is integral to any healthcare organization. Secondly, the corporate financial bottom line can sometimes conflict with principles of good quality care; therefore, safeguards must be put into health care reform legislation, so that full disclosure is given to consumers as to what sort of constraints and enhancements are directed

toward their physicians. This matter is well outlined in the Patient Protection Act suggestions of the American Medical Association (a copy of which I've included).

Further, this issue of blunt efforts at cost savings has implications for the questions you asked concerning discrimination against, and protective measures for, minority providers. In managed care entities, where the physician contracts to see patients in his or her own office, it is now very commonplace for these organizations to track with computers the use of resources by these physicians. Now it has been very clearly documented these last few days in Amy Goldstein's series in The Washington Post on the inequities of health care in this metropolitan area that physicians who care for older, sicker, and predominantly non-white populations may use more resources in that care. Those physicians should not be penalized in that regard because corporate financial decisions to cut such providers out is harmful to minority patients and their physicians. We at MSDC have entered into legal action against a local insurer, Blue Cross Blue Shield of National Capital Area, over its use of a computer program which Blue Cross used as a basis for decisions about which doctors to invite to participate in an insurance plan for federal employees. As far as we can tell, the decision was based on doctors' use of resources. We believe that this computer-based selection process has not been verified by chart review or outcome research. Providers who are qualified and capable -- who happen to care for sicker patients -- must be protected from this sort of thing.

I am also in favor of the provision promoted by the Congressman from Georgia, Mr. John Lewis, on "essential community providers" which ensures recognition and positive treatment of physicians and hospitals practicing in medically underserved areas. The National Medical Association has clearly defined this category of providers

and has made recommendations in this regard. (I have included this information as an appendix.)

Finally, many black and other minority physicians in my generation went into primary care given our country's needs and remain underrepresented in specialty care. Hence, assistance and consideration should be given to underrepresented minority medical students who wish to pursue specialty training, such as orthopedics, cardiology, and the like.

With regards to your final question, I have indeed witnessed major changes in my private practice in the seven years since I left the HMO. There has been a progression in which I have seen a majority of my revenue shift from the fee-for-service category to income from the three managed care entities with which I participate. There is an associated substantial increase in administrative burdens with regard to gatekeeper functions, such as pre-authorization, increased paperwork, and the like -- and this is all for a discounted fee. It is here that one can see the workings of the "dying breed" phenomenon: primary care private practitioners are drowning in overhead to now collect a discounted fee from these networks. Yet this is the model of practice which most Americans want -- a competent physician, who is oriented toward preventive medicine, who uses cognitive services rather than expensive procedures to enhance a person's well-being, and who is accountable directly to his or her patients for access and quality.

Hence, in conclusion, I have few suggestions: first, that in healthcare reform legislation, you work toward significant reductions in the paperwork and redtape hassles that providers confront by enacting a universal claim form; that you establish a minimal benefits package of covered services by all insurers which physicians can

recognize and work with; and that any healthcare reform legislation should foster a reduction in the unnecessary build up of middle management which is occurring now.

Further, we must keep the accessible, accountable physician office available to a public which is at least responsible for some part of the cost of its healthcare. Hence, healthcare reform should keep the choice of a private physician who, as a qualified willing provider, is available to his/her patients.

Finally, I did not lay out the case for federal legislation for malpractice suit tort reform, but cannot overemphasize its importance in healthcare reform.

THE PATIENT PROTECTION ACT (S. 2196, H.R. 4527):
SAFEGUARDS FOR PATIENTS IN AN IMPROVED MARKETPLACE

- The Patient Protection Act (PPA) would significantly advance patients' interests through disclosure and choice. It would require plans to give patients the type of information necessary for them to make sound consumer decisions, e.g., enrollee satisfaction statistics. It would require plans to disclose their utilization review rules and physician credentialing standards to patients and physicians. The thrust of the PPA is information, not federal regulation of plans. Such information is essential to the proper functioning of the health insurance market and to the protection of patients as consumers.

- By definition, managed care plans hold down costs by restricting access to services and providers. Thus they have an automatic advantage in the marketplace, particularly when potential enrollees are not adequately informed of all the restrictions that keep premiums relatively low. Requiring disclosure, and also requiring that health plan sponsors offer options, where available, (managed care plan + traditional insurance plan + benefit payment schedule plan) would level the playing field.

- The PPA would not require any extensive federal certification bureaucracy -- the Secretary may defer to any state or private accreditation system and treat plans certified through such systems as meeting the requirements of the PPA. Two private accreditation systems, the Utilization Review Accreditation Commission (URAC) and the National Committee for Quality Assurance (NCQA), have already been established by the third-party payer industry. The Act merely seeks to ensure a uniform minimum level of protection against the documented abuses of some managed care plans.

- Many of the provisions of the PPA are so clearly necessary that they were incorporated in the 1993 Guidelines for the Conduct of Managed Care, a monograph published jointly by the HIAA, BCBSA, CIGNA, and the AMA. Those principles which appear in both the Guidelines and the PPA include:

    - Disclosure of what services are covered and what services are excluded; disclosure of enrollee financial responsibility, utilization review requirements, and financial incentives restricting or requiring the use of specific physicians or services;

    - Criteria for participation in a managed care plan should be based primarily on professional qualifications and quality of care rendered. There must be an appeal mechanism for physicians terminated "for cause;" and

    - Physicians must be allowed meaningful input into the establishment or modification of plan medical policies, including utilization review criteria and procedures.

- Similarly, many of the PPA principles on utilization review criteria, reviewer qualifications and review procedures appear in the 1989 Guidelines for Health Benefits Administration developed jointly by the AMA, HIAA, and BCBSA, and other organizations.

CONGRESSIONAL BLACK CAUCUS

AFRICAN AMERICAN COMMUNITY REQUIREMENTS OF HEALTH CARE REFORM

CONSENSUS PROVISIONS AND LEGISLATIVE PRIORITIES

JUNE 1994

AFRICAN AMERICAN COMMUNITY REQUIREMENTS OF HEALTH CARE REFORM

Essential Community Providers

Essential community providers shall be defined to include:

- Historically black hospitals,
- Federally qualified health centers,
- Rural health clinics,
- Family planning clinics,
- Maternal and child health providers,
- AIDS providers under the Ryan White Act,
- Hospitals receiving disproportionate share payments, and
- Rural primary care hospitals.
- Individual health providers who:
  - serve one or more than one Medically Underserved Areas or Health Professions Shortage Areas for a total of at least 20 hours per week, or a neighborhood or community in which persons reside who are at-risk of under-service and spend at least 20 hours per week at the principal site and are available to patients evenings and weekends at the principal site; and
  - if the individual provider is a physician, he or she must also be [i] board certified, or board eligible [ii] hold hospital staff privileges, or [iii] is affiliated with one or more physicians holding staff privileges.

Provisions protecting essential community providers.

- It is mandatory that any health reform legislation must include a provision that requires health plans serving either medically underserved or health professional shortage areas [as defined by Health and Human Services under 330 and 332 of the Public Health Service Act] to contract with "essential community providers" or demonstrate that they can provide the same health care delivery system that would be provided by the essential community providers.
- Health plans shall be required to contract with essential community providers on terms as favorable as those under contracts with other providers.

- Health plans shall be required to reimburse essential community providers no less than the reasonable costs rates required by 1833[a] of the Social Security Act.

- The "essential community provider" contracting requirement shall remain in effect for ten years.

- At the end of the ten years, the Secretary of DHHS shall provide a report on the program to the Congress.

Standards for qualifications and regulations

- The Secretary of the Department of Health and Human Services shall be required to set standards for qualifications of providers not automatically certified, consistent with the Act.

- The Secretary of the Department of Health and Human Services [DHHS] shall be required to develop regulations implementing the program and establishing certification and health plan notification procedures within six months of enactment.

- Essential community providers shall be eligible for construction bond guarantees under FHA 241 and 242 programs jointly administered by DHHS and DHUD.

Mr. TOWNS. Thank you very much for your testimony, Dr. Ellis. Dr. Fobbs.

Dr. FOBBS. Chairman Towns, I am Dr. Fobbs from Fresno, CA, representing both myself, the Golden State Medical Association and the National Medical Association and I would like to thank Representative Stokes. He advised us.

Mr. TOWNS. He is a doctor. In health care, believe me, he is out there.

Dr. FOBBS. And a doctor in the service. I would like to point out some of the areas that both the NMA and myself would like to, as a group, make it clear that we support. We strongly support the any willing provider concept and I would like to explain that.

Managed care, and I won't go through the text that I have already prepared, but managed care is a double-edged sword. We enthusiastically support managed care. Managed care can be very good, it can be very productive but managed care can also be very damaging and very bad.

One of the things that you all—we would like for you all to legislate is ethical behavior which, as you know, you can't do, and the problem with that is you can only legislate so much and then people take things and do what they will. The problem with managed care, I say the good part about managed care is that it encourages good care, early care, and health maintenance. The bad part about managed care is that a simpler way to control it is to exclude providers and to form tighter networks and so-called premium networks where providers are handpicked and many providers are excluded. It is very—it is much simpler to control a half a dozen or a dozen providers than 30 or 40. The mathematics is just very simple. This is what Blue Cross did in Washington, DC, and this is usually done not on the basis of quality, but on the basis of cronyism and the good ol' boy network, which I comment about in my text.

The other thing it has done, which Dr. Arindell has alluded to, is that usually in these forums, minority physicians are the first to be eliminated and because the managed care network requires no explanation, they give no explanation, and in my—in my evidence brief that I submitted, I have the testimony of several doctors who simply got notices from the managed care organization, that is, we just don't need you right now, and this went on for 1 year, 2 years, 3 years, 4 years, 6 years, and very often during this time, dozens of other doctors in their same specialty were being accepted who were not black, or who were not female.

In the case that I pointed out in Fresno, they actually excluded females and black females when there were no females in the gynecology section, and I think we all know that there has been a deficiency of female gynecologists forever and they are very, very wanted and very, very clamored for by the female population whom they serve, and these people actually excluded all the females because they happened to be minority, one was Hispanic and the other was black and this goes on regularly.

The other part about eliminating doctors in peer review, and I did speak a lot about peer review because I had a personal experience which I thought was interesting. I was the only African-American OB-GYN in one large hospital system which also had a man-

aged care component, and by being probably too innovative and doing too many things ahead of my white colleagues, I was a recipient of the wrath of those and was charged, probably much as Dr. Arindell alluded to with many false allegations, all of which have been proven to be fraudulent and contrived, however, it did produce the same situation that she spoke about. You have to defend yourself. You have to try to keep your license. You have to try to not get thrown out of other managed care plans because that blight on your record must travel wherever you go, and in my case, this had been going on for years, 6 years, and fortunately, all of the other managed care plans were able to look at the evidence and all the other hospitals were able to look at the evidence and discard those accusations, but they were difficult and they remain difficult for many years because once they are on your record, you are in that guilty-until-proven-innocent situation, despite what we say constitutionally.

Those are my key concerns. I think that in regards to managed care, I would certainly like to disagree with the persons, again, who could not recognize the need for any willing provider. I think that any willing provider demands more managerial input from managed care plans. It means you have to take all qualified—any willing means, any willing qualified provider. We are not talking about people who are questionable and marginal. It means you have to spend more time with more doctors setting down guidelines, reviewing performance, and basically making—paying attention to carrying out good medicine across the board.

It is certainly more difficult when you have more providers, but without it, doctors will be—they will be discriminated against and they will be excluded for no reason, and that will happen to a large percentage disproportionately to African-American and other minority providers because this is still America and that is the way it works.

[The prepared statement of Dr. Fobbs follows:]

DENARD M. FOBBS, M.D.,
CERTIFIED DIPLOMATE
AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
GYNECOLOGY, LASER AND MICRO SURGERY, INFERTILITY, LIMITED OBSTETRICS

President--Daniel Hale-Williams Medical Forum
President-Elect--Golden State Medical Association

Congressman Edolphus Towns
Chairman-Subcommittee on Human Resources
and Intergovernmental Affairs
B-372 Rayburn House Office Bld.
Washington, D.C. 20515

Dear Representative Towns and members of the committee:

As an African-American health care provider I hope that health care reform will provide broad and appropriate access to quality health care for all Americans.

As the same African-American health care provider, who has served in the trenches of reformed and unreformed health care in Fresno, California for fifteen years, I fear that the proposed health care reform might set the cause of African-American and many other minority and majority physicians BACK many years. And might additionally worsen the plight of poor and minority citizens, already gravely stricken by inadequate care and tragic life conditions.

For the most part African-American physicians have always been subject to racial discrimination in medicine and out of medicine. As general societal conditions improved, so did those in medicine. But the specter of racism and racialism have never completely abated and in this new health care climate of managed care and managed competition the problem of discrimination and disparate treatment rises to new heights.

Now as never before those who would discriminate, and they are many, have a new and potent weapon to reinstitute and reinforce cronyism and the good -ole- boy system of discrimination against minorities and selected majority physicians and expanded opportunity to enjoy the fruits of preferential treatment and exclusionary policy.

Until recently, prevailing law and hospital policy have reasonably guaranteed qualified physicians a right to state licensure and hospital staff privileges with access to patient pools by virtue of those two criterion, which made certification for participation in most any insurance provider panel a certainty.

125 E. BARSTOW, # 104 • FRESNO, CA 93710 • (209) 225-7600

In the recent past hospitals and doctors who would close hospital staff rosters for their mutual profit and control of health care dollars and access have been thwarted by the law and in most cases access was maintained.

With the coming of the new health care, managed care, now it is perfectly legal to combine, collude and conspire to limit, control and deny health care access to undesirable patients (i.e. poor, minority) and undesirable doctors (minority, new, better trained or more skillful than self, independent). The new system now encourages the same behavior that took the past twenty years to outlaw and restrict.

Now physicians with an inside tract in a hospital managed care system can legally commandeer exclusive contracts and establish exclusive physician provider panels that may be entirely arbitrary and even capricious but always allegedly just business (nothing personal)---just business. These same physicians who always wanted to close hospital staffs, stifle competition and develop closed fiefdoms in public and private (quasi-public) hospital systems now have the necessary instrument to do so.

For many years and to present the classical method of hospital damage control, (exclusion of unwanted physicians) has been by way of contrived peer review and harassment. Through dishonest and disparate methods in peer review, targeted doctors have been in essence run off by vicious and repetitive advisarial peer review proceedings. These measures are always punctuated with the thinly veiled threat that with the slightest valid irregularity the aggrieve doctor would be reported to a licensing board with recommendation for revocation of licensure.

My personal experience has been very much like the scenario described:
My practice of Obstetrics and Gynecology in Fresno, CA. was uneventful until my decision to obtain privileges at St. Agnes Hospital in about 1984. Prior to that time I had enjoyed practice at Fresno Community Hospital without incident.

I had first been informed that I would be unwelcomed at St. Agnes by my program chairman during residency. "They'll eat you alive" Dr. George LaCroix told me prior to finishing residency, about the staff at St. Agnes. They don't want anyone new, not of their own choosing, he told me and certainly they don't want anyone new and black.

I was met by open hostility at St. Agnes hospital and within the first two years was brought before the departmental review body on several occasions, allegedly for some medical practice impropriety. On each occasion I was able to demonstrate

beyond any doubt, that the allegations of the review committee were false, poorly conceived and inappropriate. It is no wonder then that the attitudes of the members of the review committee worsened.

Those attitudes took a quantum leap in negativity in about 1985 when I was the first gynecologist in Fresno to embrace laser surgery. I quickly learned and became proficient in both performing and teaching these techniques, much to the dismay and hostility of my colleagues at St. Agnes, who tried every trick to block my progress and that of the remainder of the community. The remainder of the medical community embraced this new technology however.

Despite massive resistance I pressed on until about the summer of 1987 when I was again the first to introduce Advanced Laparoscopic Laser Surgery to Fresno. This was clearly too much for the old guard at St. Agnes to bear and before long they had enlisted the peer review process to resoundingly criticize several laser surgical cases and whatever questionable cases they could find. They began with four and ended with a total of eight cases which in their infinite wisdom were poorly managed.

Based on this pattern of activity it is not surprising that in the middle of the night without warning, reason or input my privileges were summarily restricted. This was done inspite of the fact that all patients initially cited had perfect outcomes and were pleased with the results.

IN SUMMARY:
The entire action had been made based on lies, fraudulent records, misrepresentations and half-truths.

1. In the first case which took three and 1/2 hours (a normal time period unbeknownst to them) they accused me of taking FIVE hours.
2. Second case; perfect out come for endometriosis treatment. They criticized time of surgery ; at three hours was perfectly normal. Just delivered patients first baby about eight months ago.
3. Third case, perfect outcome with laser treatment for endometriosis in two stages first at laparoscopy and second at laparotomy.
4. Fourth case; accused of doing hysterectomy for no reason by virtue of "normal path report". In fact path report was ABNORMAL showed endometriosis and infection. And patient had severe pain for over a eighteen month period. KEY: Path report was fraudulently or negligently submitted. Pain completely gone.
5. Fifth case; accused of perforating uterus of patient because of FAT in path specimen and accused of transfusing too much blood.

Page 4.

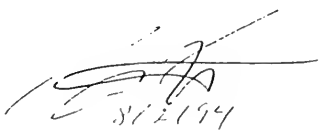
KEY: Path report FRAUD again--No fat. No perforation. Anesthesiologist ordered blood. Patient did perfectly.
KEY: In a similar case another St. Agnes doctor DID perforate the uterus during D&C, caused massive bleeding, bowel injury, emergency hysterectomy and bowel resection. In the judgment of these same reviewing doctors this case was perfectly well managed?
6. Cases 6, 7, and 8. Similarly flawed: 6 and 7 with perfect outcomes and no valid criticisms. And case 8. Accused of doing emergency C-Section of preterm baby for no reason at all (baby had compromised outcome with RDS).
KEY: Chart showed mother in severe screaming and writhing pain, but chart was tampered with by hospital and that evidence removed. A full page of nurses notes corroborating my diagnosis was removed from chart prior to early review.
KEY: The fetal heart rate monitor strip was removed from the record. It showed fetal distress and possible abruptio--all emergencies justifying the treatment given.

SUMMARY: Early in my proceedings with St. Agnes hospital this case was referred to the Dept. of HHS. After much ado and review HHS found St. Agnes not in violation of civil rights statutes. This was however before we had found this litany of fraudulent documentation upon which the hospital built it's case. With a true and accurate record and the evidence of fraud and deceit by the hospital I will resubmit the charge of civil rights violations to HHS and on the charge of malicious and negligent peer review with express anti-competitive intent I will request the Justice Department take this and several other related physicians cases for investigation.

FINALLY: Because of behavior like this a dangerous precedent is established. Strong and wealthy hospitals can willfully bend, malign and break the law with impunity---they have the resources to defend themselves against the indefensible.

These same health care institutions are now leading alliances to manage health care. In Fresno St. Agnes is ValuCare. As you might expect from the earlier discourse, African-American physicians have been excluded in mass from this organization--and so have many other minority and majority physicians as well or better qualified than many who were accepted. This denies physicians access to their patients and blocks patient access to their physicians. This breeds the sorriest sort of health care delivery debauchery.

In an unregulated system uncivil and disruptive activity will prevail. Any willing qualified provider is thus essential. And in poor, inner city and underserved communities---Traditional (Essential) provider networks must be maintained. They are the only providers proven to be effective, committed and culturally sensitive. These relationships must be the foundation for growth and repair of this system.



Evidence in Support of Discrimination in Managed Care

Supplement to testimony of
Denard M. Fobbs, M.D.
125 East Barstow, Suite 104
Fresno, California 93710

CENTRAL IPA, INC.
THE ATRIUM

October 15, 1990

Quita Lopez, M.D.
681 Medical Center Dr. West #106
Clovis, CA 93612

Dear Dr. Lopez:

The Central IPA Board of Directors has reviewed your letter of August 28. Your application to contract for service to ValuCare members was again reviewed at the September meeting of the Board of Directors.

Your application to contract was not approved.

Thank you for your interest.

Sincerely,

Robert L. Duerksen, M.D.
President
Central IPA, Inc.

JC:jp

IPA2-90.322

Matrix
PHYSICIANS OF CHOICE...

August 25, 1992

Quita Lopez, M.D.
681 Med. Ctr. Dr. West, #106
Clovis, CA 93612

Dear Dr. Lopez:

Thank you for your inquiry regarding participation as a Matrix/ValuCare provider. We shall keep this information regarding your request on file.

You will be contacted in the event it is decided that a formal application is needed.

Very truly yours,

SH.

Sharon A. Hurley
Professional Relations

SAH/sas

P O Box 25790, Fresno, CA 93729-5790, (209) 435-2614, FAX (209) 435-7693

Quita Lopez, M.D.
Obstetrics & Gynecology

681 Medical Center Drive West, Suite 106 — Clovis, CA 93612
(Next to New Clovis Community Hospital)

(209) 323-0370
(if no answer 228-2386)

December 9, 1993

Randy Hawks
Vice President of Operations of Value Care
Matrix
P.O.Box 25790
Fresno, Ca 93729

RE: Denial of provider aplication

Dear Mr. Hawks:

Please consider this letter formal notice of my intend to pursue legal action against your organization for failure to allow me to become a participating provider.

I have applied numerous times and have not received any response to my inquiries regarding the cause of the denial.

Your organization has sought out another female OB/Gyn specialist and accepted only one female, yet ignored my application and inquiries. Studies indicate an increase in patient desire to seek treatment from female providers and there is a limited availability of female providers within the OB/Gyn specialy for Matrix.

I consider your lack of action discriminatory, prejudicial, and an attempt to restrain trade. Unless I receive a written response to the reason why I have not been allowed to become a participating provider or access to become a preferred provider within seven days from the date of this letter, I will have no recourse but to consult my attorney.

Sincerely,

Quita Lopez, M.D.

QL/sg

CC: Board members

Law Offices of
FORREST & McLAUGHLIN
A Professional Corporation

Theodore R. Forrest, Jr.
William T. McLaughlin II
Ronald A. Henderson
John H. Mussrhan
Kenton J. Klassen
Steven D. Huff
James F. McBrearty
Timothy R. Sullivan
Jerry Namba

2115 Kern Street, Suite One
Fresno, California 93721-2100

Telephone : (209) 233-3730
Telecopier : (209) 233-8930

April 19, 1993

1-2019

W. L. Brown, Sr., M.D.
W. L. Brown Medical Corporation
2828 Fresno Street, Suite 201
Fresno, CA 93721

Re: Tower Health Services

Dear Dr. Brown:

Please find enclosed for your records a final copy of the letter I sent out last week to the Department of Health Services.

Yours truly,

FORREST & McLAUGHLIN

Theodore R. Forrest, Jr.

THEODORE R. FORREST, JR. (RJM)

TRF:kjm
Enclosure

Law Offices of
FORREST & McLAUGHLIN
A Professional Corporation

Theodore R. Forrest, Jr.
William T. McLaughlin II
Ronald A. Henderson
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Telephone : (209) 233-3730
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April 14, 1993

1-2019

Joseph A. Kelly, Chief
Managed Care Programs Branch
Department of Health Services
P.O. Box 942732
Sacramento, CA 94234-7320

Re: Tower Health Services

Dear Mr. Kelly:

This firm has been retained to represent W. L. Brown Medical Corporation and W.L. Brown, Sr., concerning your letter to Barbara Aved, Ph.D.

Please be advised that my clients are not interested presently, nor do they anticipate being interested in the future, in joining or associating with Tower Health Services.

By copy of this letter to Tower Health Services, my clients are also putting them on notice that any reference in any form to the effect that one or both of my clients support, are associated with, or interested in being associated with Tower Health Services would be false and misleading and illegal under numerous states laws, including Business and Professions Code section 17500, which states, in part:

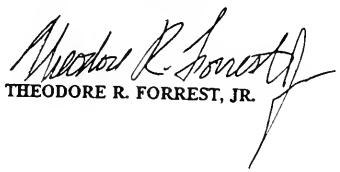
> "It is unlawful for any person, firm, corporation or association, or any employer thereof with the intent directly or indirectly to dispose of...or to perform services, professional or otherwise, ...to make or disseminate or cause to be made or disseminated before the public in this State...any statement, concerning such...services, professional or otherwise, or concerning any circumstances or matter of fact connected with the proposed performance or disposition thereof, which is untrue or misleading, and which is known, or which by the exercise of reasonable care should be known, to be untrue or misleading..."

In the event untrue or misleading statements are made involving my clients, I have been instructed to take immediate legal action, which would involve the filing of a complaint and obtaining a temporary restraining order against any such statements.

Should you have any questions or wish further information in regard to the subject matter stated herein, please feel free to contact me at your convenience.

Yours truly,

FORREST & McLAUGHLIN



THEODORE R. FORREST, JR.

TRF:kjm

cc: Ben Carranco, Contract Manager
Tower Health Services

When I applied ~~to~~ tower Health they told me that if I got in to the program I could still see Dr. Browns office with my medical still saying Tower Health. I ~~so~~ asked them again to make sure I can come see Dr Browns office for my pregnancy they said yes. So I applied. But now they wont cooperate. They stated that they were associated with Dr. Brown.

Veronica Cuenca

3-28-72

(6-17-93)

GOLDEN STATE MEDICAL ASSOCIATION

An affiliate of the National Medical Association, Inc.
4477 W. 118TH STREET, STE 303, HAWTHORNE, CA 90250
(310)676-0148 FAX (310)644-3147

May 29, 1994

Governor Wilson
Office of the Governor
State Capitol
Sacramento, CA 95814

Dear Gov. Wilson:

The Golden State Medical Association, representing African-American consumers and providers, has been apprised of the recent decision to permit Care America, a division of Uni-Health , to recruit patients in the South Central Los Angeles area for their medical managed care program.

This is a majority company based in a geographically distant location. We request the state to suspend this process immediately Any other intrusion by a majority company should be stopped immediately.

Hearings should be held regarding the sudden intrusion and infringement upon long established patient physician relationships.

The Golden State Medical Association feels this sudden shift in health providers adversely impacts the implementation of an effective multicultural provider group utilizing essential community providers already established in these areas

Such activity sets a dangerous precedent that would negatively impact the recognized tenuous health status of this targeted population.

It has been well established that the exclusion of minority medical providers has a negative impact on minority patients. The effect of such action violates the civil rights of both the minority patients and physicians involved, and is in violation of stated policy

We would appreciate your prompt response to this letter.

Respectfully,

Randall W. Maxey, M.D., Ph.D.
President

Walter H. Morris, M.D.
Immediate Past President

RM:WHM/tlc

cc. Senator Diane Watson, Chair, Health & Human Services
Ms. Kimberly Belshe, Dir. Calif. Dept of Health Svs
Senator Barbara Lee, Chair, Black Caucus
Assemblyman Willie Brown, Speaker

DENARD M. FOBBS, M.D.
CERTIFIED DIPLOMATE
AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
GYNECOLOGY, LASER AND MICRO SURGERY, INFERTILITY, LIMITED OBSTETRICS

July 17, 1994

Sheryl E. Forrest
Legal Coordinator
CAPP CARE - National Corp. Office
West Tower- 4000 MacArthur Blvd. Ste.1000
Newport Beach, CA 92660-2526

Dear Ms Forrest:

I am in receipt of your letter of inquiry regarding the San Francisco Recorder article of April 11, 1994. As you can imagine the referenced suspension from the staff at St. Agnes Medical Ctr. is very old news but deserves some clarification.

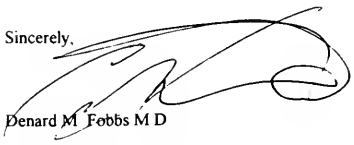
Firstly the matter of suspension was importantly a matter of my election and choice. As the enclosed information will show, the actions and interpretations of the hospital and it's functionaries were at all times faulty--therefore after an adequate period of time attempting to work within the hospital's system of biased peer-review I chose to abandon the hospital and it's staff and seek legal redress.

Rather than resign from the staff I felt it more appropriate to protest the dishonesty and corruption of their peer review procedures and demand a fair and just review process or suspension. St. Agnes chose suspension over the granting of a fair hearing on the issues---and understandably so---as it was proven at subsequent review after review by several dozen individual physicians, numerous medical staffs, the Golden State Medical Society, The Northern California Physicians Council (NORCAP), and the Medical Board of California , **the charges by St. Agnes had no merit and were contrived.**

I will include a summary of these charges and their answer. This should show more than adequate refutation of the accusations and remove any doubt about my standing as an OB/GYN specialist in this community. I am confident that you, as the dozens of health care organizations before you have concluded, will agree that my professional expertise is certifiable and the charges and actions of St. Agnes hospital are suspect and presently appropriately subject to judicial review of the grounds of biased and discriminatory peer-review conspiracy

If additional information might be helpful please feel free to contact me again
I have purposely abridged this information in order to not overwhelm you with material but if desired or necessary much more detail is available
Thanking you in advance for your considerations of this matter and the facts supporting my actions in this multifaceted affair

Sincerely,



Denard M Fobbs M D

cc Community Physicians of Central California

Page 1

Regarding the Medical Board of California (MBC) Accusation: **ALL CHARGES WERE DISMISSED; FOUND TO NOT BE SURPORTED BY THE FACTS.**
The accusation of the Medical Board regarding three "3" cases stem from the original accusation of Saint Agnes hospital involving eight "8" cases. These considerations of the three cases cited by the medical board must in part be combined with the eight original cases from St. Agnes in order to gain reasonable perspective.

I wish to first avoid a pointed argument against each and every accusation levied by the medical board and the hospital. This will be submitted later. First I would like to present a personal profile which I believe will begin to show how unlikely the accusations of the MBC and St. Agnes are to be true.

1. I submit my CV and the October 10, 92 letter of Dr. Weiner to the Medical Board and deputy attorney general Gail Heppell.

You will see nothing of a profile in these to suggest a reasonable likelihood of physician deficiency.

In Addition to the above I submit the following :

2. After the prior noted charges by St. Agnes were a matter of public record,

a. Fresno Community Hospital, Sierra Community Hospital, Valley Children's Hospital, and Valley Medical Center (including the U.C. San Francisco Medical Education Program) all undertook the necessary peer and incident reviews required by their respective staff bylaws. These representatives of over 750 Fresno County physicians who **know me and my accusers** at St. Agnes well found no substance in the accusations or fault in my practice patterns.

b. All of the above approved renewal of full privileges without restriction or prejudice after complete review of the charges and my performances. These recertifications have occurred again and again since the original charges in 1987.

c. Additionally;
I was newly added to the staff at Clovis Community Hospital after these charges were made. With complete and unrestricted privileges being given in 1989 after complete consideration of the accusations regarding all eight cases. The inescapable conclusion being that these combined medical staffs who again, know me and my accusers at St. Agnes so well continue to invalidate their accusations, conclusions and their judgment---not mine.

3. Again after the charges of St. Agnes (SAMC) were levied,

a. On recommendation of the principals of the San Joaquin Surgical Center staff. The principals of the Houston Laser Institute an affiliate of Baylor College of Medicine elected me to their panel of certified preceptors. To teach and instruct in the same discipline which SAMC and later the MBC chose to make the accusations The Houston Laser Institute used over a hundred cases in their review process.

b.In my capacity as preceptor in Laser and Advanced Laparoscopic surgery I have helped train Residents in the UCSF program and continue to do so.

c. I have trained many of my peers in OB/GYN and General Surgery including the present and past three department chairs in OB/GYN at Community Hospitals of Central Calif Paradoxically I also trained a one point or another most of the members of the OB/GYN dept at SAMC in Laser Surgery before they became disorientated and accusatorial.

4. I Also submit as promised some of the specific responses and documents in response to the accusations.

a One most telling address to the accusations and one which addresses the matter in a somewhat parallel mode to any managed care network is the NORCAP review.

The Northern California Physicians Council undertook a complete case by case review with input from the staff at SAMC and my self when in response to the original accusation and 805 report of SAMC to the MBC my malpractice insurer NORCAL considered the accusations serious enough to recommend not renewing my policy if the accusations were valid

I am very happy to note, as the inclusions with this packet show, that the eight physicians who reviewed all aspects of these cases found **nothing to support** non-renewal, surcharge, reprimand or anything else adverse in regard to all eight cases. And NORCAP was forced to do two separate reviews . Because the board at NORCAL could not believe what over 700 doctors in Fresno have been saying for six years; These charges are not and never have been believable.

5 Information was disclosed recently which makes the credibility of the charges by SAMC, and those who relied on them at the MBC even more embarrassing.

Page. 3

a The nurse who brought the original accusation to the hospital, and whose report was relied upon to carry the adverse action, was not available to testify in behave of the hospital or the MBC.

This nurse, Karen Jenkins is in prison.

Convicted of **felony fraud , criminal and administrative violations** by the effort of the Board of Registered Nurses.
This is the person whose false and malicious report was the foundation of the hospitals case

b.As a last example of how poor and inaccurate maybe even negligent the reviewers at SAMC and the MBC were.

1 Take the third case of the medical board,
But first note that even the medical board with it's faulty and apparently jaundiced review,—Threw out five of the cases submitted by SAMC , and stated that they thought they were invalid criticisms.

Again looking at the third of the three cases left;
This is a case based on nothing but a piece of fat in a D&C specimen. The patient did fine there were no valid problems noted but SAMC and the MBC insisted that I perforated the uterus and tried to hide it, because there was fat in the D&C specimen.
I have perforated a uterus before and do not hide it. I feel it is an undesirable but probably unavoidable complication on rare occasion.
But these two review bodies decided that despite no clinical evidence and nothing seen at laparoscopy, and my testimony, that I had to have done it because of fat in the specimen.
They ignored more plausible possibilities such as a "floater" (contaminant) in the specimen.

Please see Dr. David Hadden's Report:

There was no FAT in the specimen. The slide was just misread.
This slide was reviewed by Dr. Hadden and his Associate, ---**no fat there.**

2. In the first case the major criticism was always that this poor 25y/o had no problem, no pathology, and no reason to have a TAH-BSO. **NOT TRUE.**
This patient had over two years of incapacitating pain She understood her options and the effects of the surgery. She was offered ovarian perservation but was explained the risks She was fully participatory in the decision.
An inadvertent pregnancy termination, of a clearly abnormal pregnancy,occurred The patient had been on continuous birth control pills, was having regularly irregular periods for a year and bleeding regularly and heavily prior to surgery.

Page. 4

There was no growth of an admittedly large uterus for three weeks prior to surgery. Good evidence of no pregnancy or non-viable pregnancy. But it was missed and should not have been. A mistake , not bad practice.
Even the reviewers for SAMC admitted that the missed pregnancy was not the problem.

The real problem was that not only did this patient have a good historical reason for her surgery and good informed consent.

She did have the pathology as stated pre-operatively on the slide. It was just under read.

Again see Dr. Haddens report (Dr. Hadden is also the Fresno County Coroner)
It shows the chronic inflammatory changes described at laparoscopy pre-op. And it shows the decidual changes that are consistent with this patients pre and post-op course
Her results were excellent. She was and still is my patient and one of my best referral sources amongst patients. And she only has pain when taking large doses of estrogen, (as we might expect of someone with endometriosis--yes?)

3. The other case criticisms are equally flawed;
please refer to the summary of Mr. Weisberg for more discussion if warranted.

4. Other points of information that bear consideration,
a. In the push for health care reform the State of Calif and the County of Fresno has formed a "Regional Health Care Consortium" , I am a member of that consortium to develop the regional m.. .aged care plan for Medi-Cal, the County and private providers.
b. I am a member of the Quality Assurance committees at Fresno Community Hosp. and Clovis Community Hospital.
c. I was recently elected Vice-President of the Golden State Medical Assoc
Notably the chair of the election committee was Dr. Ezra Davidson Chair of the Dept OB/GYN Drew Post Grad Medical Ctr. and immediate past president of the American College of Obstetrics and Gynecology (ACOG). Dr. Davidson has reviewed these cases and I believe his actions display his contempt for the actions of SAMC and the MBC's, earlier judgment.
d. I continue to enjoy an expanding role with Community Physicians of Central California I participate in several dozen of their managed care plans and have recently been invited to join their IPA and it's expanded managed care role.

. I can assure you that this and the other major health care operatives in this area would not reject the positions of SAMC and the MBC if they were other than wildly unsurportable and off the mark factually and procedurally. Recently and after complete review of all the facts regarding the accusations of SAMC, I have been admitted to Blue Shields and Blue Cross'es HMO.

No. 92-15852

IN THE UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

DENARD M. FOBBS, M.D.,

Plaintiff and Appellant,

vs.

HOLY CROSS HEALTH SYSTEM CORPORATION, a California Corporation, doing business as SAINT AGNES HOSPITAL and MEDICAL CENTER; CYNTHIA BERGMANN, M.D.; JAMES CAHILL, M.D.; JAY CHRISTENSEN, M.D., CHARLES GAVIN, M.D.; SEUNG NAM KIM, M.D.; ROBERT MELTVEDT, M.D.; MARSHALL NOEL, M.D.; MARTIN ROSENSTEIN, M.D.; ROYDON STEINKE, M.D.; ROBERT WILSON, M.D.; and LARRY E. NIX, M.D.,

Defendants and Appellees.

Appeal from United States District Court for the Eastern District of California, Case No. CV-F-89-682-REC Robert E. Coyle, Judge

Argued and Submitted April 12, 1994 San Francisco, California

---

PETITION FOR REHEARING AND SUGGESTION FOR REHEARING EN BANC

TRITT & TRITT
JAMES F. TRITT, ESQ.
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4720 LINCOLN BLVD., SUITE 200
MARINA DEL REY, CA 90292
(213) 821-1163

Attorneys for Plaintiff and Appellant, DENARD M. FOBBS, M.D.

No. 92-15852

IN THE UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

DENARD M. FOBBS, M.D.,

Plaintiff and Appellant,

vs.

HOLY CROSS HEALTH SYSTEM CORPORATION, a California Corporation, doing business as SAINT AGNES HOSPITAL and MEDICAL CENTER; CYNTHIA BERGMANN, M.D.; JAMES CAHILL, M.D.; JAY CHRISTENSEN, M.D., CHARLES GAVIN, M.D.; SEUNG NAM KIM, M.D.; ROBERT MELTVEDT, M.D.; MARSHALL NOEL, M.D.; MARTIN ROSENSTEIN, M.D.; ROYDON STEINKE, M.D.; ROBERT WILSON, M.D.; and LARRY E. NIX, M.D.,

Defendants and Appellees.

Appeal from United States District Court for the Eastern District of California, Case No. CV-F-89-682-REC
Robert E. Coyle, Judge

Argued and Submitted April 12, 1994
San Francisco, California

PETITION FOR REHEARING AND SUGGESTION FOR REHEARING EN BANC

COMES NOW Appellant, DENARD FOBBS, M.D., and hereby petitions this court for rehearing of the above-entitled appeal, and hereby suggests that a rehearing en banc be granted.

INTRODUCTION

In the judgment of counsel for appellant, DENARD M.

TOPICAL INDEX

TABLE OF AUTHORITIES

FEDERAL CASES

STATUTES

FOBBS, M.D., this petition for rehearing and suggestion for rehearing en banc is justified on three grounds:

1. Material points of fact and/or law have been overlooked;

2. These proceedings involve questions of exceptional importance concerning the construction and application of the Health Care Quality Improvement Act of 1986, 42 U.S.C. 11101, et seq., a statute which has previously been interpreted by this court only in Austin v. McNamara (9th Cir., 1992) 979 F.2d 728;

3. A rehearing en banc is necessary to secure uniformity of decision within this circuit, in that this court's decision in the instant case conflicts with this court's decision in Austin v. McNamara (9th Cir., 1992) 979 F.2d 728, concerning the applicability of the standards of the Health Care Quality Improvement Act of 1986 to peer review actions preceding the final peer review hearing.

The opinion from which this petition arises overlooks appellant's contention that the HCQIA standards must be applied to each peer review action, not merely the first and last; overlooks the statutory requirement of 42 U.S.C. section 11112(c)(2) that summary action, subject to subsequent notice and hearing or other adequate procedures, may only be taken in peer review where the failure to take such an action "may result in an imminent danger to the health of any individual," combined with appellant's evidence expressly showing that there was no imminent danger related to appellant's practices and respondents' failure to produce any

evidence establishing the potential of imminent danger; and conflicts with this circuit's decision in Austin v. McNamara (9th Cir., 1992) 979 F.2d 728, wherein the existence of an admittedly proper final hearing did not prevent this court from analyzing the earlier hearings during the peer review process.

ARGUMENT

I. THE PANEL OVERLOOKED APPELLANT'S EVIDENCE OF NO POTENTIAL FOR IMMINENT HARM, COMBINED WITH RESPONDENT'S FAILURE TO PRODUCE EVIDENCE SHOWING THE POTENTIAL FOR IMMINENT HARM, AND THE HCQIA REQUIREMENT THAT SUMMARY ACTION ONLY BE TAKEN WHERE THE FAILURE TO TAKE SUCH AN ACTION MAY RESULT IN AN IMMINENT DANGER TO THE HEALTH OF ANY INDIVIDUAL

The Health Care Quality Improvement Act of 1986 only permits summary action "subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual." (42 U.S.C. §11112(c)(2).) The panel discounts this requirement of the Health Care Quality Improvement Act of 1986 by noting that the statute:

> . . . does not require imminent danger to exist before a summary restraint is imposed. It only requires that the danger may result if the restraint is not imposed. (Opinion, p. 7932; emphasis added.)

If that observation of the panel is intended to suggest that summary action may be taken even in the complete absence of any evidence of imminent danger to the health of any individual, merely because there may be such a danger in the future, then the panel has completely eliminated all protections for all doctors from summary restrictions of privileges. Literally in any case of

medical care, where that care is questioned, someone could hypothesize a scenario in which "imminent danger" might result to some individual in the future.

Thus, for example, a physician might have a practice in an emergency room of a hospital wherein a person coming to the hospital complaining a headache during allergy season might be released with pain medication and told to watch the headache, particularly where that person had a history of allergy-related headaches. The hospital committee might decide that it is better, in the case of a patient coming to the emergency room, to conduct tests to rule out a brain tumor. The physician might be subjected to peer review proceedings over his or her practice of not performing such tests. However, it is submitted, no reasonable person would believe that there was imminent danger to any individual from that physician's practices. Under this court's analysis, if the word "may" is construed to refer to the indefinite future, summary restrictions would be justified merely because the person with the headache might at some time in the indefinite future be subject to imminent danger if it turns out that the headache was caused by a brain tumor.

The point is that in literally every case of medical treatment -- or the failure to treat -- there "may" at some point in the indeterminate future be "imminent danger" to some individual. Under this court's interpretation of the statute, hospitals and peer review committees will have no incentive to ever provide a physician with notice and hearing procedures before

subjecting the physician to privilege restrictions. Because it is always possible to conjure up hypothetical scenarios involving possible future "imminent danger," hospitals and committees may with complete immunity restrict the privileges of physicians before giving them any notice or hearing procedures. Such action could always be justified on the theory that there "may" -- at some time in the indefinite future -- be imminent danger to some individual, and that is all that is required under this panel's analysis.

The evils of such a statutory construction are profound. First, it is a fact of life that a physician who has been summarily restricted is placed on the defensive through the remainder of peer review proceedings. All subsequent panels and hearing officers cannot avoid the knowledge that some previous committee has already restricted the physician's privileges. In this very case, Dr. Fobbs suffered that precise prejudice. Panelists were of the view that subsequent hearing committees were to decide not the merits of the case against Dr. Fobbs, but merely whether the original summary restriction was appropriate. (ER, pp. 112, 225-226; Brief of Appellant, pp. 13, 43.) Thus, Dr. Meltvedt informed the first judicial review panel that its duty was merely to determine whether "the imposition of the monitoring was reasonable and warranted at that time," referring to the summary monitoring. (ER, p. 216.) Similarly, Dr. Bergmann stated that she understood "merely that we are to decide whether the decision that was rendered by the Executive Committee was appropriate or not," in imposing the summary monitoring. (ER, pp. 225-226.)

Second, the panel's interpretation of the statute effectively strips physicians of all due process protections. Since it is true that in every case some committee could conceive of some circumstances which "may" suggest imminent danger to some patient in the future, it follows that in every case a committee could impose summary restrictions on the physician with complete immunity. All the committee would have to do was restrict the physician, then subsequently offer notice and a hearing. The physician thus loses his privileges, and then must attempt to convince subsequent committees to reinstate those privileges. Panels have therefore received the right to engage in anti-competitive conduct with complete immunity. Since none of the prior hearing requirements apply, groups of direct competitors may actually put their competition out of business without a hearing -- asserting in every case that there "may" be imminent danger.

Third, under this court's interpretation of the statute, the physician is not even permitted to challenge the committee determination of "imminent danger," even though the only evidence bearing on the point establishes that there was no potential for imminent danger. Thus, the physician is also deprived of his right to a trial in a case in which there is a legitimate factual dispute as to whether or not there was any basis for a determination of potential imminent danger. In the instant case, Dr. Cooke testified that there were no health emergencies to justify the summary restriction of Dr. Fobbs' privileges on June 23, 1987, and Drs. Cooke and LeCroix submitted declarations establishing that on

or about June 23, 1987, Dr. Fobbs' standard of care did not pose an imminent or foreseeable future threat to patient well being. (Brief of Appellant, p. 42; ER, pp. 260-264.) Drs. Cooke and LeCroix expressly stated that the summary restrictions were inappropriate. (ER, pp. 260-264.)

Not only was there no evidence in the record establishing any foreseeable imminent danger, but the panel should recall that at oral argument the attorney representing the physician defendants was asked by Judge Trott to point to any evidence in the record suggesting imminent danger, and admitted that he could not do so.

In a case where the appellant has produced evidence of no potential imminent danger, and the respondent at the oral argument conceded the absence of evidence establishing imminent danger, to affirm a grant of summary judgment on the theory that the statutory word "may" allows peer review committees to side-step the "imminent danger" requirement, runs counter to fact and law and effectively rewrites the statute. The Congress might just as well have eliminated the whole "imminent danger" clause from the statute and allowed summary restrictions at the will of the peer review committees, based upon the panel's construction of the statute. The panel has unquestionably ignored the word "imminent." The panel therefore has overlooked the factual development of this case as well as the Congressional choice of language in the statute. Contrary to both, the panel has allowed peer review committees to impose summary restrictions without any evidence of actual or potential imminent danger, thus depriving all physicians of any

semblance of due process before they lose their privileges.

The panel's opinion seemingly concedes as much. While there is generic reference to "problems caused by Dr. Fobbs," there is no reference in the opinion to any evidence of patient harm, threat to a patient, or actual or potential imminent danger, present, past, or future. (Opinion, pp. 730-732.) Thus, in addition to overlooking the foregoing factual and legal issues, the opinion is defective in overlooking the express evidence through Drs. Cooke and LeCroix of no potential imminent danger, and no justification for the summary restrictions. To uphold summary judgment on such a record is contrary to the notion that summary judgment is only appropriate where the appellant cannot raise a triable issue of fact. Here, appellant not only raised a triable issue of fact, but was the only party producing any evidence on the issue, and appellant's evidence established that there was no actual or potential imminent danger by reason of appellant's practices.

II. THE PANEL OVERLOOKED APPELLANT'S CONTENTION THAT THE HCQIA STANDARDS MUST BE APPLIED TO ALL PEER REVIEW ACTIONS, NOT MERELY THE FIRST AND LAST

The panel in this case, following the lead of the trial judge, only considered the first and last hearing in assessing whether the HCQIA requirements had been met. There is no discussion in the panel's opinion concerning any peer review actions other than the initial summary restriction. By its affirmance of the trial judge's written opinion, it is inferable that the panel agreed with the trial judge that only the first and

last peer review action were to be evaluated. The trial judge completely ignored all the intermediate peer review actions and hearings which were admittedly defective. The trial judge addressed one of appellant's arguments -- that the HCQIA standards should apply to all conduct of the peer review system. (ER, p. 299.) The trial judge rejected appellant's contention that the HCQIA standards must be met by the professional review activity taken as a whole; the trial judge instead decided that the HCQIA requirements and immunity applied to "discrete professional review actions/decisions." (ER, pp. 297-298.) The panel, in adopting the trial judge's decision, apparently adopted that conclusion.

However, the panel conspicuously overlooked the most significant contention advanced by Dr. Fobbs in this appeal. That contention is not addressed in the trial judge's opinion either. That contention is that even if the HCQIA immunity requirements apply to discrete actions/decisions, in the context of the instant case that means that such requirements must be applied to all of the intermediate evidentiary hearings -- not merely the initial summary restriction and the final hearing (or non-hearing) in the case. The evidentiary hearings resulted in decisions -- professional review actions -- by judicial review committees. (See ER, p. 244.)

In the instant case, there were approximately seven distinct peer review hearings/actions to which the HCQIA standards should have been applied. Both this panel and the trial court ignored approximately five of those actions. As stated by

appellant in his opening brief:

> At a minimum, the HCQIA standards must applied to all of the hearings and all of the summary actions in this case. Thus, the standards must be applied to the July 23, 1987 action, the hearings of September 15, 1987, and September 24, 1987, and the hearing of January 25, 1988, in addition to the hearing scheduled for August, 1988. The act was designed to apply to all evidentiary hearings. To ignore the intermediate hearings would be to countenance months, or even years, of improper anti-competitive conduct provided only that the last of a series of hearings complied with the HCQIA standards. (Brief of Appellant, p. 39.)

Dr. Fobbs was subjected to defective peer review "discrete" actions/hearings on, and in decisions resulting from hearings on, September 15, 1987, September 24, 1987, and January 25, 1988; Dr. Fobbs had to pursue two appeals related those actions/decisions. (Brief of Appellant, pp. 11-14.) As a result of those defective hearings, peer review "actions" were taken. (Ibid.; see also ER, p. 244 and discussion at Brief of Appellant, pp. 39-44.) Those hearings -- at least the hearings of September, 1987 and January, 1988 -- were admittedly defective. (Brief of Appellant, pp. 39-44.) It was because of those defects that the board of trustees on administrative appeal granted further hearings. (Ibid.) Both the panel and the trial judge have completely ignored those defective "discrete" actions.

Ignoring the defective intermediate hearings and decisions will produce mischief and evil in peer review. Hospitals and committees now have the complete right -- with immunity -- to subject a physician to an unending series of defective hearings until the physician exhausts his resources in fighting the peer review. When the physician finally gives up, the hospital can hide

behind his withdrawal from the proceedings as an excuse for non-compliance with HCQIA standards, and can obtain immunity for itself and for all peer review committee members, including members of earlier defective panels. This issue was specifically proffered not only in the brief of appellant, but also in the reply brief of appellant, at pages 17-22. The failure of the opinion to address this issue merits a rehearing, and the importance of the issue merits a rehearing en banc.

III. A REHEARING EN BANC IS NECESSARY TO SECURE UNIFORMITY OF DECISION WITHIN THIS CIRCUIT

By omitting to consider the application of the HCQIA to the admittedly defective hearings of September, 1987 and January, 1988, and decisions resulting therefrom, this court has created a conflict with its prior decision in Austin v. McNamara (9th Cir., 1992) 979 F.2d 728. The hearings of September 15, 1987, September 24, 1987, and January 25, 1988 were admittedly defective due to failure to permit voir dire of panel members and other defects. (See Brief of Appellant, pp. 10-14, 39-44.) In Austin v. McNamara, this circuit held that the type of professional review action which is addressed by the HCQIA is an action or recommendation which affects (or may affect) adversely the clinical privileges, or membership of a professional society, of the physician. (Id. at p. 730.)

As pointed out in appellant's reply brief at pages 17-18, that definition would encompass all of the hearings and resulting decisions in this case. Thus, HCQIA standards, according to

Austin, must be applied not merely to the June 23, 1987 action, but also to the hearings of September 15, 1987, September 24, 1987, and January 25, 1988, and the decisions resulting from those hearings. (See ER, p. 244.) By failing to apply HCQIA standards to those hearings and decisions, the decision in this case is in direct conflict with the decision in Austin, in which the propriety of previous hearings was considered, even though the physician in Austin received an admittedly proper final hearing. By reason of this conflict, a rehearing en banc should be granted in this case.

CONCLUSION

For the reasons stated, appellant respectfully requests a rehearing as to the portion of the decision which addresses the Health Care Quality Improvement Act of 1986. Because consideration by the full court is necessary to secure uniformity of its decisions and because the questions presented are of exceptional importance, the rehearing should be en banc.

DATED: August 1, 1994

Respectfully Submitted,

JACOB M. WEISBERG
JAMES F. TRITT

By: _____
JAMES F. TRITT
Associated Co-Counsel for
Plaintiff/Appellant

(PROOF OF SERVICE BY MAIL - 1013a, 2015.5 CCP)

I am employed in the County of Fresno, California. My business address is 1540 E. Shaw Avenue, Suite 115, Fresno, California 93710. I am over the age of eighteen years and not a party to the within action.

On August 1, 1994, I served the within PETITION FOR REHEARING AND SUGGESTION FOR REHEARING EN BANC by placing a true and correct copy thereof enclosed in a sealed envelope with postage thereon fully prepaid on the party(ies) listed on the attached Mailing List.

I am **readily familiar** with the business practice at my place of business for collection and processing of mail for mailing with the United States Postal Service, and that mail so collected and processed is deposited with the United States Postal Service that same day in the ordinary course of business.

I declare under penalties of perjury that the foregoing is true and correct, that I am employed in the office of a member of the bar of this court at whose direction the service was made, and that this declaration was executed August 1, 1994 at Fresno, California.

_____

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Mr. TOWNS. Thank you very, very much, Dr. Fobbs.

Dr. Watson.

Dr. WATSON. Thank you, Chairman and all those here. Excuse me for one thing. I am from the 1960's and 1970's and sometimes I still use black instead of African-American, so I hope that will be tolerated here today.

On behalf of my many colleagues in Kansas City, I bring you greetings and extend to you our sincerest and best wishes for your deliberations during one of the Nation's most important debates. For the next few weeks or months, you will decide whether all Americans, black and white, rich and poor, passive and assertive, healthy and unhealthy, will be accorded access to the level of health care in this country equal to our Nation's proclaimed legacy, that being the right to life, liberty, and the pursuit of happiness.

And in doing so, you are inexplicably challenged to have the courage and forthrightness to stare history directly in the face and vow, once and for all, not to repeat it. Our country's efforts in the past have resulted in African-American physicians being treated worse, given less and having less stature in our communities and cities.

An example I pose is Medicare. We have to look at the past in order not to repeat its errors. Black physicians, I am told, wanted Medicare and thought it would be good because now they would be paid something for patients they saw free in the past. I am told that the white community as a whole did not agree with this and were reluctant about Medicare. The interesting thing is that those that wrote the regulations decided, among other things, to pay physicians based upon their office location and their previous charges. Well, guess who previously charged less? Black physicians. Guess where the poor areas more than often happened to be? That was in our neighborhoods. So we were paid much less for the same service.

Think of what that means. That means that my tax dollars went to pay other physicians more than me for the same services that I render. That is hard to take. That goes on today.

Just make an honest and unequivocal attempt to grasp the gravity my Democratic Government is saying to its African-American physicians. In effect, our Government says that your medical degree isn't as credible, your diagnosis isn't as correct, and your medical treatment isn't as valuable as your counterparts.

That, ladies and gentlemen, is but a small part of history that is staring us in the face. This is the history that we must not repeat.

Now in the 1990's we move toward—or forward in an age of managed care programs. Now we have a continuum and the suffering increases. Before, the patients that we took care of many physicians didn't want to have anything to do with. No money, a lot of work, worse health care, and so forth. Now we have these programs which take our patients and assign them to white physicians.

We have talked about today where people live. Black doctors primarily practice around black people. White doctors primarily practice in the suburbs or near suburbs. This creates somewhat of a problem for transportation. Seems small, but a lot of my patients

are—used to be patients, say this is a big problem, if they do manage to get there. Let me just give you some quotes. These are personal experiences that I know of and that my patients relate to me and they are not unusual, so I don't want you to take this as though it is some aberration.

One patient was told by a provider they were assigned to "we don't know how to draw blood on black patients." My wife, in a hospital I primarily practice at, was told by a nurse, "I can't start an I.V. on you. You are black." One doctor that I know told me, "I give McDonald's medicine to black patients and Cadillac medicine to white patients." This doctor was assigned a large number of our patients.

I also have seen the sign that says, "no black men allowed." This is by a gynecologist just treating pregnant women. Their husbands can't even come there. What does he think of our community and our neighborhoods and our society? And these things didn't happen a long time ago. I am talking about instances that happened this year and last year, not a long time ago.

So what happens when we have these patients that can't get to these doctors' offices. They don't go. Preventive care decreases, acute and more extensive and expensive care increases and the cost of that bad medical care skyrockets and we all foot the bill for it.

The next step is one says, well, these patients don't have a doctor, and this is happening and has happened right in Kansas City now and over the last few years. They don't have a doctor, yet we are right there ready to serve them and have served them for years. So we said, what are we going to do. Well, we are going to form a clinic.

So then we spend millions per year to create and maintain clinics in the neighborhood of the patients. Now these same patients who have their own black physicians in the neighborhood must go to a clinic with long lines, delays, and unfamiliar physicians; and I am personal care, and I mean I am personal oftentimes. OK, I will—I guess I will stop and I will hope that you can ask me a question so I can continue.

[The prepared statement of Dr. Watson follows:]

August 3, 1994

HEALTH CARE REFORM AND BETTER HEALTH CARE FOR BLACKS?

Mr. Chairman, Ladies and Gentlemen of Congress:

On behalf of many of my colleagues, in Kansas City and around the country, I bring you greetings, and extend to you our sincerest and best wishes for your deliberations during one of this nation's most important debates. For the next few weeks or months, you will decide whether all Americans, black and white, rich and poor, passive and assertive, healthy and unhealthy, will be accorded access to the level of health care in this country equal to our nation's proclaimed legacy - that being the right to life, liberty, and the pursuit of happiness.

And in doing so, you are inexplicably challenged to have the courage and forthrightness to stare history directly in the face and vow, once and for all, not to repeat it. For in our country's past efforts to right the wrongs suffered by Americans without insurance, those health care professionals who care the most were compensated the least. Those health care professionals who shared the most were awarded the least and, those health care professionals who sacrificed the most were recognized the least. For example, in the mid 1960's, the Medicare program was created. In general, African-American physicians supported the concept. They reasoned that with Medicare, they would begin to get reasonable compensation for the disproportionate numbers of indigent patients they were treating. It is my understanding, on the other hand, that white physicians, in general, were less enthusiastic about Medicare. After all, the patients they treated most often had health care coverage and were able to meet their fees for service. Some of them declared that Medicare was the sole precursor to socialized medicine. None the less, Medicare legislation was passed.

When the regulations governing payment schedules and reimbursement procedures came on line, the African-American physicians were given short shrift. The Medicare regulation writers decided that reimbursement for services would be based on, among other things, the location of a physician's office, as well as the amount of money he or she had previously charged. The regulation writers deemed that physicians with certain locations should be reimbursed less than physicians with offices in different locations. That is, some physicians were paid less than others for the same procedures. What this means is that I, a black physician, pay taxes so that I can receive less money for the same service than a white physician. How unfair! In addition, the regulation writers prescribed that since the compassionate African-American physicians had in the past, accepted the meager scrimp-and-scrap payments of their honorable but sorely indigent patients, it would be no travesty of moral or fiscal policy to reimburse them less than their white colleagues. Image the audacity it takes to institutionalize such a blatant discrimination into a major component of our country's health care system! Medicine giving way to location-based payments, and mercy being

trampled by the mean-spirited avarice. Forget the sheer magnitude of the additional paperwork, the plethora of forms, and the administrative mishmash such gerrymandering Jim Crowism must have produced!

Just sanely and humanely attempt to understand the deleterious impact this type of institutionalized inequality renders to those physicians whose compensation and caring lead to their locations in under-served, low-income areas: and who, over the years, provided the only professional medical treatment their indigent patients could obtain. Just make an honest and unequivocal attempt to grasp the gravity of the Democratic government saying to it's African-American physicians, in effect, that your medical degree isn't as credible, your diagnosis isn't as correct, and your medical treatment isn't as valuable as that of your white counterpart.

That, ladies and gentlemen, is but a small part of history that is staring us in the face. That is the history that we must not repeat. And, that is the history relative to our nation's last foray into the realm of health care reform that gives pause for concern to thousands of minority, and especially African-American physicians across the country today. We are hoping and praying that the health care reform legislation of the 1990's will not be laced with the insidious disparity and rife with the hobbling, hindering, and handicapping regulatory implements thrown at us in the past.

Today, in the 90's, we move forward in this age of managed care programs. Now we have a continuum and the suffering increases. Those patients the majority of the community preferred not to care for are now assigned to white physicians. As the crisis continues, these previously reluctant physicians are given the very patients we have loved and treated for years. These decisions are, again, made by under-informed white leaders, who once again, hurt the very people they supposedly represent. Now, in many instances, the patients cannot get to the new white physician's office, which is oft times located in or very near the suburbs. In view of the very segregated nature of our major cities, it would be no surprised to know that most white physicians practice in white areas of town. Thus, the problem with transportation. If black person's get to these offices, the services are just not the same in many instances.

Black people often hear, once at these offices, that "we don't know how to draw blood on black people." "The doctor would not touch my hair, so how could he treat the sores in my scalp?" I have been told by a white physician that, "I give McDonald's medicine to black patients and Cadillac medicines to white patients." I have also seen a sign at the entrance of a white physician's office which read, "No black men allowed." These quotes are not in the distant past. The above instances all occurred within the last two years and happened involving managed-care programs.

So, what happens when these patients have to go to these reluctant physicians in distant localities? They are bounced around clinics and care is delayed. Preventative care decreases. Acute and more extensive and expensive care increases and the cost of bad medical care skyrockets. I assume this is the exact

opposite of the intent of the under-informed decision makers. The next step is usually then to decide that involved patients cannot get good medical care. Then we spend millions per year to create and maintain clinics in the neighborhood of the patients. Now these same patients, who have their own black physicians in the neighborhood, must go to the clinic with long lines, delays, and unfamiliar physicians, and impersonal care (and yes, we get calls all night from patients as they hardly can ever get clinic doctors after hours) and all at greatly increased cost. Now, instead of going to their family physician who have two employees, we now have directors, assistant directors, comptrollers, secretaries, transcriptionists, etc. to pay. All of these people, who never treat the patient, must get paid before the doctor, nurse, lab, or x-ray is paid. Because the patient base has been taken away, black physicians often have to move. This now creates a permanence to the horrible situation. The patients then have no option but to use the traitorous system, which not only provides bad medical care, but results in inevitable tremendous cost.

It should be stated that in my experience over the last 19 years, the managed care systems seems to always be in place with patients and physicians before we, the black physicians, hear about it. We are always left attempting to be included after the fact. This results in our getting less than our share of the patients. In addition, there is often a discrepancy between the black primary care physician and the black specialist. One or the other is included. At first glance, one might say, "So what?" The real issue, is that essentially no white physicians refer to black physicians, whereas the reverse is not true. Thus, if only black primary care physicians are in a program, they cannot continue to use the specialist they know and trust and with whom they have a relationship. If only black specialists are in the program, it tends to be only another plan which has us as a statistic. This is because you know you will never get referrals from the majority community of physicians. Therefore, no referrals, no patients, no income. There are many anecdotes and specific examples of the injustices in medicine. The conclusion any reasonable person would reach, based on available information, is that those that made the unjust system will only continue it with the new health care initiative. How can we hope for anything different when the same persons making the decisions get information from those not really knowledgeable of the plight of blacks in America.

To cope with the many changes brought about by the domination of medical care by those who do not treat the patients, black physicians have had to do what all physicians have had to do: we decrease our overhead and join as many organizations as possible. We work twice as hard for about half the pay. This is so devastating to the medical community as a whole, one might lose sight of the even greater devastation done to black physicians. Because our base is smaller, and our options so limited, the problem is greatly increased. To begin with, we make less money. Losing $50,000, if you have an income of $150,000-$200-000 is bad, but livable. Think about losing $50,000 if your income to start with is only $70,000? Once again, you can see that there is a difference in black and white lives.

Health Care Reform and Better Health Care for Blacks?
Page 4

There is hope for the black community and the health care system if anyone would listen. I am certain that many who read this will not take it seriously as they have not had the same input as me. I do not judge anyone's life based on my experiences, and I hope that no one will judge me based on theirs. As often happens, those who live in a totally different environment will look you in the eye and tell you that what you have experienced is not true. How arrogant! We must get past this so that we will have validity based on our different experiences.

Here are a few of the things that must be done for the health reform bill to really help:

1) Patients must be free to choose their providers.

2) Black providers must be seen for what they are, essential community providers. For so many reasons, cultural and otherwise, the persons we care for have special needs, which at this point, only we, black providers, can and will provide.

3) There must be an active effort to bring together, rather than splinter, the collective caregivers – hospitals, primary care physicians, and specialists.

4) Decision makers must get information from practicing black physicians about health care in the African-American community.

5) You must take into account that the past and present affects, the various policies and programs have had on the black community.

6) You must acknowledge that we, the African-American physicians care for sicker patients with more advanced diseases, which cost more to treat. The result is that we are by definition "high utilizers." More than once, good doctors have been put out of managed care programs for being "high utilizers." Preventative medicine, more often than not, is a luxury in our community.

Herman Watson, M.D.

Mr. TOWNS. Thank you very much, Dr. Watson, for your testimony. We have been joined by Congressman Payne who is a member of the subcommittee and I would like to recognize him at this time and ask him if he would take the chair. I have to run and offer an amendment and be involved in health care with the Energy and Commerce Committee. So I recognize you, Congressman Payne.

Mr. PAYNE [presiding]. Thank you very much.

Let me, first of all, indicate to the panelists and to those in the audience and, of course, those who have come and left, that I want to commend the chairman, Ed Towns, for his leadership in calling this hearing this morning. I would also like to extend my regards to those of you who are panelists, many of you who have traveled many miles to get here and we feel it is that important that we all take a very strong interest and concern in what is going on in this area of health care.

The issue of health care is looming large on this Nation's agenda and President Clinton deserves much credit for keeping health reform in the news. Much of the contention with health care reform has lately focused on employer mandate. However, less attention has been focused on the segment of the population, as you all have so ably stated, the population that has historically been disproportionately denied access to our Nation's health care system, our communities of color. The health care industry has been adapting itself to accommodate the anticipated changes in this Nation's health care system and these structural changes are modeled after the HMO system.

The President's proposal for health care reform sets the stage for this restructuring of the Nation's health care system. Most of the plans released subsequent to the President's have used this model for so-called reform. However, these plans fail to recognize that minorities face special problems in this new system of managed competition, and as you have been indicating these things and you know it much better than I.

These communities have historically been denied access to the same services as the mainstream and traditionally these communities have relied on alternative methods of seeking their health care and this separate system has become their sole source of health care. In this alternative system, there is an alternative group of providers, mostly minority, who have set up practices in medically underserved communities.

Historically, these providers have maintained an independent status because their practice has served largely at-risk underserved populations. For example, only 3 percent of Americans' physicians are African-Americans or black, and African-Americans constitute 12.4 percent of the American population. Hispanics are more underrepresented in the nursing profession than any other ethnic group, including native Americans.

There are a number of insurance companies who are opposed to provisions in the plan that would require them to offer equitable terms to duly qualified minority providers because traditionally, they have gone unchecked and locked these various central providers out of the health care system, as has been indicated.

So I wanted to commend the chairman again for this very important hearing and also state how pleased we are that we do have our Dr. Stokes who has really been a leader in the whole question of health care, health care reform, and is the person that we really look to for our guidance, and he has done such an outstanding job in this whole very important and complicated area.

I would ask, Congressman Stokes, if he has any questions for the panel.

Mr. STOKES. Thank you very much, Mr. Chairman, and I certainly appreciate your kind remarks. Just a couple of questions.

Dr. Arindell, I listened intently to your testimony and I have also read your full written statement here and I am really concerned about what happened to you and particularly from the viewpoint of being concerned to what degree and to what extent this is happening to other persons who happen to be minorities in the field. And I notice here, you had worked for Kaiser Permanente about 3 years.

Dr. ARINDELL. Correct.

Mr. STOKES. When this happened you had just returned from serving our country in the Persian Gulf; is that correct?

Dr. ARINDELL. Well, I went to—I was stationed in Germany. I didn't actually go to the Persian Gulf, but went on active duty in Germany.

Mr. STOKES. Before you were a board certified anesthesiologist, isn't that correct?

Dr. ARINDELL. Correct.

Mr. STOKES. Where did you receive your training?

Dr. ARINDELL. At Johns Hopkins.

Mr. STOKES. What did that consist of? How many years study?

Dr. ARINDELL. Three years of anesthesia training.

Mr. STOKES. Prior to that, what other educational qualifications had you?

Dr. ARINDELL. I went to Cornell undergrad. I went to Yale for medical school. Then I did 2 years of pediatrics and then did 3 years of anesthesia training at Johns Hopkins and my first employment was with Kaiser Permanente right out of residency.

Mr. STOKES. And then without any type of problems of any sort, this situation occurred at Kaiser?

Dr. ARINDELL. During the clinical practice, there had been five—four or five difficult intubations. I could not intubate the patient, neither could the other attendants in the department intubate the patient. Difficult intubations is not that uncommon. It is a known complication of anesthesia.

Like I said, my evaluation, June evaluation where the supervisor could have checked off clinical skills unsatisfactory or needs improvement did not. She simply checked off satisfactory and the only comment that she made was that difficult intubations continue to be a challenge. Most people would interpret "to be a challenge" as something that you need to work on.

I subsequently talked to the supervisor who was a physician and chief of the Kensington Medical Center about the evaluation as part of the routine practice and he made no mention of the fact that my share would be denied. Subsequently, I went on vacation, came back in September, found out that my share had been denied.

Met with my supervisor who told me that I needed to leave Kaiser, stop working and go seek academic retraining. I might add, though, at the same time that I supposedly needed to leave and seek academic retraining, they continued to put me on the call schedule.

Mr. STOKES. I see where you were called in in the evenings and——

Dr. ARINDELL. Right, so how could it be——

Mr. STOKES. While you were supposedly in need of retraining?

Dr. ARINDELL. Exactly.

Mr. STOKES. In order to be a part of the permanent staff. Tell us what you are doing now.

Dr. ARINDELL. I currently work as a staff anesthesiologist. I am an instructor at the Johns Hopkins Medical Center at the—used to be formerly the Francis Scott Key Medical Center. It is now the Johns Hopkins Baby Medical Center.

Mr. STOKES. One of the top medical universities in the country, I believe.

Dr. ARINDELL. Correct.

Mr. STOKES. Dr. Watson, you are a general surgeon; Is that right?

Dr. WATSON. Right. I am a surgeon in the Kansas City area.

Mr. STOKES. What type of surgery?

Dr. WATSON. General surgery is a specialty. It is kind of a misnomer, but that is the specialty that I am in.

Mr. STOKES. I see. You wanted to add something to your testimony. What——

Dr. WATSON. Well, I didn't want to go through all the other things, but I did have some recommendations that I think are very important, three or four. It will probably take about a minute or two, one is that patients must be free to choose their own provider. That is, patients should not just categorically be locked into people they don't know and don't want to go to.

Black providers must be seen for what they are, essential community providers. There must be an active effort to bring together, rather than splinter, the collective caregivers. What I mean by that is that many times you are in an HMO, not on the staff of the hospital, we have hospitals in Kansas City that are assigned patients through some managed care program and don't have physicians that can go there. There has to be some coordination of that and I think that was alluded to earlier.

The decisionmakers, and that is, I guess, all persons concerned, must get information, which you are doing today, from practicing black physicians about health care in the African-American community. So often, I am told that—by persons, that what I have experienced in my life is not correct, and that is pretty arrogant. I think all of our experiences are just and we have to understand that there are differences.

As was alluded to today, you must acknowledge that we, the African-American physicians, care for sicker patients and more—with more advanced diseases, which cost more to treat. The result is that we are high utilizers. And more than once, good doctors, my friends have been put out of managed care programs for being high utilizers.

It is kind of a no-win deal. We take care of the worst patients—when I say worst, I mean with most disease. We want to be there and if we are allowed to, by some way they allow us to be in this managed care program, then we are put out because we take care of the very patients that we have, and so it is a no-win deal. But I think if this could be—this is really important because we have high blood pressure and more of the extensive diseases.

Mr. STOKES. Dr. Ellis, did you want to add something?

Dr. ELLIS. Yes, I wanted to add in that very note that Dr. Watson just sounded, that a lot of times, it is clear from this testimony, I hope, that we must continue to attack discrimination in this society. I think the specific examples that Dr. Watson has given, Dr. Arindell has provided, are clear. But these subtle kinds of things, such as excluding doctors who take care of sicker patients, or at least using some sort of program, computer program supposedly that just uses resources consumed. We got to protect our patients. We got to protect our people from this sort of aggressive business competition, this managed competition phenomenon from, in fact, discriminating against our people and the providers who are, in fact, for years been providing care to them.

And I think that is the more subtle kind of discrimination that we see, and I think that any health care entity, any kind of managed care entity must have due process provisions in its hiring and firing of doctors that is critical as we go into these larger organizations.

Mr. STOKES. Thank you.

Dr. Fobbs.

Dr. FOBBS. Representative Stokes and the committee, I just wanted to make a couple additional comments about what we have been reviewing again. And that is that I think a couple of points is that the essential and traditional community provider concept, I think, is essential, and it would do a lot of good. Because the minority and African-American providers in these neighborhoods, if they are made and deemed by the legislature and Congress to be essential and mandated to be included, that rule forces the managed care plans to work with them and through them.

They will be incorporating providers who are experienced, who have proven that they can provide care in a cost-effective manner already and who already have established relationships with these patients. But just as importantly, those funds that don't exist that were spoken about earlier by Dr. Sullivan and others, those funds will quickly come into—come to fruition, because big groups like Blue Cross and everyone else, they seriously want to get into this managed care, this Medicaid provider network and they are perfectly willing to work with the traditional providers if they have to. Otherwise, they will do just what they normally do, which is just take their regular group of providers, which mysteriously excludes minorities.

So I think that it can do a great deal toward actually helping the whole overall system by just making it necessary, otherwise they will find other ways to take care of their business.

Mr. STOKES. Mr. Chairman, you have been very generous with your time. I would just add, for the assurance of those who are testifying here, that Congressman John Lewis, who served on the

Ways and Means Committee, that drafted the proposals from which the House leadership is now drafting the House leadership bill, which is known as the Gephardt bill, Congressman Lewis was the one who pursued that amendment in the Ways and Means bill and it has been adopted by the Congressional Black Caucus Health Braintrust in the document that we produced on behalf of the minority community. And we have been given assurance by the House leadership that the essential community provider provisions will be in the Gephardt bill, and of course we are actively at this time pursuing that and other provisions to be sure that they are incorporated in the Gephardt bill.

Thank you, Mr. Chairman. You have been very generous with your time.

Mr. PAYNE. Thank you very much.

Mr. Stokes, did you have an opportunity to talk about the Health Care Sunday? Did you speak about that in your opening remarks?

Mr. STOKES. We have not spoken about that in this forum at all, Mr. Chairman. We just haven't had an occasion to do so. But I do know that the group of doctors who are present here today are holding a meeting on that and of course it was discussed at the in M.A. convention which Congressman Bobby Scott and I attended here about a week ago in Orlando. So feel free to discuss it in that way.

Mr. PAYNE. Well, there is a request that in congressional districts, that we inform the church community that these changes are coming, that they should be informed, that we would like to get information out from the Congressional Black Caucus to alert our community about these changes.

As you know, many times our constituents are late in finding out what is going on. And we think that one of the mechanisms is certainly through the church, that we could get many of these issues on the table, so to speak, and so on, this Sunday at many churches around the country, where Members of the Congressional Black Caucus has written, the ministerial alliance is asking them to have some announcements and information.

I just quickly saw on my way here, I looked at some of the material prepared by my staff person and didn't get a chance to go through it thoroughly, but we are and have started to get some responses from actual churches, primarily M.E. churches that took a strong stand that they are going to participate in the Sunday. So through the country, the question of health care reform is going to be an issue.

Let me just say, I guess I heard most of the testimony, but let me just ask a couple of quick questions and this is for any one of the panelists.

Is it your view that HMO's second-guess medical decisions, decisionmaking, just decisionmaking in general, purely from a cost-saving basis, or do they simply have a different approach to the practice of medicine?

Yes, sir.

Dr. WATSON. I think examples speak and show many things. Just yesterday, we spent 4 hours trying to explain to a secretary for an HMO what I did. The claim was denied. Now it has to go for re-

view. It will probably be two or 3 months before anything happens. That is not unusual. The care does not help the patients.

Many times, we have to go ahead and do things and operate, knowing we are not going to get paid because we cannot get it precertified at 4 in the morning. We can't find who their—I think, and the physicians that I talk to, and that I know, white and black, all feel that managed care programs, and they won't say this loudly, are not better for the patients.

They understand about the cost, et cetera, but explain to me how it is less costly to send someone to a clinic where that clinic gets a subsidy from the government, then gets fee-for-service, more than I do, than if they just came to my office. I don't have directors, assistant directors, comptrollers, treasurers, secretaries. All these people have to be paid before the doctor, nurse, and actual people giving care are paid. It is not really cheaper. And my experience over the past years that this has come to Kansas City, if it had worked, we wouldn't be here, because health care costs would have gone down.

Dr. ELLIS. If I may, Mr. Payne, I think that your question is critical. When we talk about managed competition, we are talking about a business phenomenon and we—and it is critical that people in Congress and legislators who are attempting to come out with legislation that is going to look out for patient care know that this is not simply business. This is not a commodity, as is some other aspects of this economy.

We are talking about people's health and well-being. We are talking about a very personal thing. And that is why the bottom line is, yes, their concern generally is on economics because they are trying to survive. They clearly, with their—usually physicians, medical directors have some people in there who are making decisions that are—that have some sort of medical background.

But we and our medical organizations think that it is critical that practicing physicians have significant input into the criteria that are used, both in utilization review, as well as in selection and deselection of physicians. It is critical that those sorts of things be put in and protected in the legislation.

Mr. PAYNE. All right, thank you.

Sort of a similar question—and we are really wanting to get some testimony on the record and that is why it may sound like a duplication. But as you have indicated, given that minority populations are often sicker, as you were indicating, you know, 4 in the morning, somebody comes in and you are doing something that additional—has to be done. Since we know that our populations are sicker and respond with different interactions with health care delivery systems, in your experience, are managed care models really suited to treat large numbers of minority patients, in your opinion?

Yes, Dr. Fobbs.

Dr. FOBBS. I think that managed care models can be suited to teach—to treat large numbers of minority patients. I believe that it has been shown that large numbers of poor and minority patients probably will not go to the Ivory Tower Medical Center downtown, you have to have doctors in the community and clinics in the community, and networking as has been instituted.

And I think one of our members, Dr. Ranamaxy was very key in that, through the churches and networking through churches and organizations that live in those communities is where care really springs forth in a very sensible and palpable fashion that people will access.

So I think it is doable. I think it cuts to the issue I raised earlier about the many facets of managed care. I think managed care can be very good and managed care can be very bad. Managed care makes money and does well when they keep people healthy. They also make money and do well when they just deny care.

So—and that is the other side of the sword, is that it can—you know, you can do well by just letting people not get services. So that is—that is the duality of it. Which is why I say we really have a challenge between you legislators and we physicians, and also just members of the general public, to in some kind of way try to arrive at ethical and moral behavior in trying to address these problems. Because I don't think you can legislate everything, and we can't be every place at one time. I think we really have a problem with moral and ethical behavior.

When Dr. Arindell talks about people prosecuting and persecuting minority physicians for reasons, where if they were white, it would just be, well, you had a bad day. But it happens to everybody, but in her case, you are incompetent, that is just unethical and immoral behavior.

The same thing happens with patients. When they need care, you give it to them and sometimes you have to bite the bullet and spend the money, and sometimes you may even lose a little money in managed care because you do have a fixed income, but it all averages out with a large pool of patients and you just have to accept that.

So I think that we have to do well and be responsible, but it is hard to legislate that. I wish I could ask you all to do something that would legislate decent behavior, because a lot of the complaints that I think you are hearing from a lot of the doctors and persons here, are really an out-shoot of just immoral and unethical behavior from individuals who happen to be administering health care delivery systems, and that is another problem.

Mr. PAYNE. So actually you do—you have a dual thing. You said: First, if you keep people healthy, you make money. Second, if you deny them when they are real sick, you can unethically make money. It would appear that since our people are mainly sick, people are—or sicker, there almost needs to be a middle—some other kind of system that is going to take these sicker people and attempt to still make a profit by—but give them the care.

Dr. FOBBS. Minority physicians have already figured that out. Minority physicians have always taken care of Medicaid and Medicare patients for a lower reimbursement rate, and the way they make money is they work harder, they work longer, they see more patients and they spend less. In other words, they work with those circumstances, however difficult they might be.

And that is going to still exist in managed care because they are going to be getting reimbursed for those same patients at a lower level than the Blue Crosses and the Travelers and people like that, so it is going to be some of the same stuff. It is going to be working

harder, but it can be done. And I think that most physicians who have taken up that burden have done it in an ethical and responsible fashion, which is why you haven't heard about anything other than essentially good care from those individuals.

Mr. PAYNE. Thank you.

So doctors are just typical black Americans, you just got to work harder and do more like you all have to do to make ends meet.

Dr. WATSON. I think this is why it—excuse me. And this is why it is so important that this essential community provider be acknowledged. This is key. Most physicians that I know, white and black, state that these managed care programs are not better for the patient, period, OK. We know it is here, and the attitude is it is coming, we have got to position ourselves to deal with it, which is harder if you are black. But the—I guess the underlying problem is that after all the smoke clears, we wind up on the bottom with less, et cetera.

One example: One managed care program in Kansas City loses 40 percent of their clients every year, and they don't care, and the reason is, those are people that use the services. The people that don't use the services will tell you it is great, but those that use it wind up getting out because—and personal examples, for 3 and 4 years, people with colon cancer, breast cancer, and other malignancies are bounced around the clinic, and I wind up getting them when they have no insurance, and the malignancies, and so forth, are worse and the cure rates are less, and that is not uncommon. That is why it is essential that the community provider we are talking about addresses the issue that you brought up.

Mr. PAYNE. OK, thank you very much.

I have a whole bunch of additional questions, but I suppose that the time is moving on and hopefully we can revisit some of these questions.

I just wonder how many referrals you get from gatekeepers as black physicians. You know, I wonder, do you think they need to change the nature of medical schools to deal with this whole new question of managed care?

There are just a number of issues, but I just don't think that it is fair to the other panel—or do we have time to continue on?

But let me thank each of you for your very interesting and informative testimony. And as you can see, I could go on forever here, but I guess we better move on.

But thank you all once again.

Mr. STOKES. Mr. Chairman, before your call your next panel, I wonder if I could just say, I have got to leave at this point, but I really want to express my sincere appreciation to both you and Chairman Towns for permitting me to testify here this morning as I did, and then also inviting me to sit as a member of this very distinguished subcommittee. And I appreciate very much both opportunities provided me.

And I want to commend both of you for the excellent service I think you are rendering on behalf of the total African-American community for conducting these hearings, an opportunity of providing for our doctors and physicians and other providers, health providers, to have this opportunity to testify on this very important subject here. And I was just saying, Mr. Chairman, in your ab-

sence, how much I appreciate all the courtesies extended to me this morning, and I commend both you and Mr. Payne for the excellent service, leadership both of you are giving in this very important area.

Mr. PAYNE. I will thank you very much, Mr. Stokes, and we really appreciate your input.

I will call the last panel up and then turn the chair back over to our Chairman. Dr. Bell, Ms. Bush, Hoshi-Bush; Mr. King, Ms. Thompkins, Dr. Torres, and Mr. Van Noy.

Mr. PAYNE. We will start with Dr. Bell.

STATEMENTS OF RYLE A. BELL, D.D.S., M.S., F.A.C.D, NATIONAL DENTAL ASSOCIATION; SUSAN HOSHI-BUSH, P.T., DIRECTOR OF PHYSICAL MEDICINE AND REHABILITATION, MARY WASHINGTON HOSPITAL; ROBERT W. KING, PRESIDENT AND CHIEF EXECUTIVE OFFICER, COMMUNITY HOME MEDICAL; PATRICIA TOMPKINS, R.N., M.S., NATIONAL BLACK NURSES ASSOCIATION; SARAH TORRES, Ph.D., R.N., PRESIDENT, NATIONAL HISPANIC NURSES ASSOCIATION; AND RICHARD VAN NOY, CONSOLIDATED CRITICAL CARE, INC.

Dr. BELL. Good morning, sir.

Mr. Chairman and members of the committee, I am Dr. Ryle Bell, professor of dentistry, Howard University, and a practitioner of dentistry in the Washington, DC area. This morning I represent the National Dental Association who thanks you for this opportunity to participate in this very important discussion.

I speak with cautious optimism and real concern for the legislation proposed for the Nation's new health plan. It appears to me that for minority health providers to survive this health care reform, the repercussions of many of the recommendations must be recognized and understood and steps taken to level the playing field where necessary. Racism is still alive and well in the United States and it is very evident in the relationship between minority health care providers and the managed care system. I will give a few examples and then make some recommendations from the dental association.

In Washington, DC, for example, one of my colleagues related to me that a quality assurance team was sent to her group practice and as a result of the onsite review, the group was dropped. They were not even informed by the plan. They discovered this when the patients tried to reenroll. They challenged and discovered that there was no reason for dropping them from the plan except that the patients were going to be reassigned to nonminority providers. This obviously is a blatant attempt to terminate a provider group of long-standing with over 1,000 satisfied patients in an effort to resign those patients to nonminority providers.

Every fall my fellow colleagues and I brace ourselves for what is known as the open season, because it is during that season that most of our patients change their medical and dental insurance plans. Most of the patients are obliged to switch plans not because they are dissatisfied, but because of the decisions made by the employers. Many times it appears as though my patients and I get caught in the managed care catch-22.

On one hand, we are blocked out of panels because we are told the provider pool is saturated, yet the patients complain it takes 6 to 8 weeks to get appointments. You would expect then that the plan's administrators would add more providers, but they do not and the reason for this is because it would cut into their profit margins. It is very simple; the more people who pay their premiums, and less who use the services, the more money the plan makes. And this is the exact problem that we, as dentists, have with most of the managed care situations. They are designed to discourage patient utilization, not to increase care to the patients.

In Los Angeles, for example, we have a problem with general dentists who refer patients for better care, find that their checks are—have money deducted every time they make referrals. In Maryland, the CIGNA Dental Health Care Plan, for example, actually reduced its capitation rates and lowered patient copayments in order to underbid all their competitors. They never told their providers anything about this until about a year afterward.

In Philadelphia, all of the black oral surgeons in Philadelphia, and there are five of them, were shut out of the PRUCARE, Prudential HMO, and the Aetna Health Plan, supposedly because the panels were filled, despite the fact that 30 to 35 percent of the plan's subscribers are from the African-American and other minority communities. And I could go on and on, but I think that you got the picture.

And so the National Dental Association would like to take this opportunity to make some recommendations to solve or to, at least, address some of these problems. The problems that we see basically for managed care is that they, one, exclude and terminate African-American providers, particularly the specialists. There is a lot of arbitrary reassignment of patients, especially if those patients belong to African-American providers. There is a great dismantling of community-based private practice infrastructure and the redlining by ZIP Codes in a low-income area.

By this, this is what I mean; most medical insurances reimburse providers based upon the ZIP Code of your practicing. So, if I do a procedure on a patient in southeast, Washington, DC, and another dentist does exactly the same procedure at 18th and K downtown, the reimbursement is entirely different. I may end up getting reimbursed half as much as he does, or she does, providing the same level of care.

The National Dental Association suggests that dentistry should not be an adjunctive service. It should become a primary care service, and it must receive adequate and appropriate funding consideration. We feel like reciprocity ought to be a must across this Nation, to allow health professionals the ability to provide care and services in those areas where they are needed most. You must explain the definition of the essential community provider, expand the definition of the gatekeeper to include general dentists and to provide and select culturally sensitive professionals to evaluate systems for quality and benefit to their communities.

And finally, we must insist on proportionate representation of African-Americans in all governing, credentialing, and quality assurance boards. This should include notification to all African-American employers of any new managed care started in their areas,

which includes an invitation for them to join such a plan. We think this will help level the playing field and give the minority provider an opportunity to compete and perhaps survive.

We thank you for this opportunity to present testimony and offer ourselves in any role of aid to this committee.

Thank you.

Mr. PAYNE. Thank you very much.

[The prepared statement of Dr. Bell follows:]

Chairman Towns and other distinguished members of the House Subcommittee on Human Resources and Intergovernmental Relations, I would like to thank you for inviting the National Dental Association to present testimony during this important hearing. I come before you to represent the poor, the disenfranchised and disadvantaged, and I speak for them out of frustration and despair recalling the inadequacy of health care in this country for the past thirty years. I speak for them with cautious optimism and a real concern for legislation proposed for the nation's new health plan. The health status of minority patients will be directly effected by access to services, the availability of minority providers, the scope of the basic benefits package, affordability, and the elimination of discrimination in health care. Of particular concern to me is the delayed inclusion of basic dental benefits for adults. Although there are elements of managed care systems that can have a positive effect on my patients, there are also many elements that are preventing us from caring properly for our patients and are causing us grave concern.

In Washington, D.C., one of my colleagues related to me that a quality assurance team was sent into her group practice and, as a result of the on-site review, the group was dropped from the plan without even knowing of the decision. They learned they were no longer affiliated with the plan when several of their patients who were attempting to renew their enrollment told them that the group practice was no longer in the plan. Upon learning of this, the group immediately arranged for a meeting with the C.E.O. and other executive-level members of the plan. During that meeting the group pointed out that in the eleven years they had been providing services, there had never been one complaint filed against the group and their patient enrollment was over 1,000 members. They demanded to see the actual results of the review, that another review process take place immediately, and that a thorough investigation be conducted by qualified reviewers. When this was done, the decision to terminate the group was reversed. The group demanded that letters of apology and retraction be sent to the entire membership pool of approximately 30,000 patients. This was a blatant, but failed, attempt to terminate a provider group of longstanding with over 1,000 satisfied patients in an effort to reassign those patients to non-minority practitioners.

As a private practitioner here in Washington, D.C., every fall my colleagues and I brace ourselves for what is known as "open season." For it is during this "open season" that our patients decide whether they will keep their current dental insurance or change to another dental plan. Most of these patients are obligated to switch plans because of decisions made by their employer. It is always anybody's guess as to how many patients will join the mass exodus of out of one practice and into another practice. The requests for records and x-rays to be sent to other locations trickle in, along with apologies and explanations of

patients having to leave my practice because their dental plans have been changed.

But just as cost conscious employers compare different plan benefits, providers also weigh the benefits of participating in various plans. For those of us "fortunate" enough to have received several informational packets, the selection process is simple and analytical. What are the reimbursement levels? How will the co-pays affect my overhead?

Every year I have to weigh very carefully my ratio of fee-for-service patients and managed care patients. I don't like having to drop out of plans and having to tell disappointed patients that I can't afford to treat them any more because their plan doesn't cover my basic expenses. But I have no choice. And every year, my small staff and I review the revised fee schedules to see whether we will still be able to remain in the plan.

In the Washington, D.C. area, average capitation rates to dental offices range from $4.00 per individual per month to $9.00 per family per month. Managed care premiums for those same plans, on the other hand, can range from $120.00 per month for an individual to nearly $300.00 per month for a family. There are approximately thirty-eight managed dental care plans in the D.C. metropolitan area. Because of the influence of the Federal Government, dental benefits have become increasingly popular, and every year there is an influx of new dental plans into our area.

I know colleagues who in the past ten years have been in and out of more than a dozen plans. They add them and drop them depending on patient volume and whether or not the plans are minimally profitable. I say <u>minimally</u> profitable because most dental practices cannot sustain themselves on managed care plans alone. In fact, it would be virtually impossible for me to offer my own small staff health benefits from income derived solely from managed care.

Many times it seems as though my patients and I are caught in managed care's Catch 22. On the one hand, I have been wait listed for over a year in my application process to one of D.C.'s more popular dental managed care plans. The excuse I am given is that the plan's provider pool is saturated. On the other hand, I hear from the plan providers and frustrated patients that the average appointment time for a tooth cleaning is six-to-eight weeks and many dissatisfied patients are trying to find other practices where they won't have to wait so long for an appointment.

If providers are wait listed to be plan participants, and if patients are searching for more plan providers, then why aren't plans administrators adding more providers? This would certainly increase access and availability. But actually allowing patients to receive care in a timely manner and allowing providers to

deliver care would cut into the profit margins of the managed care plan. And as we see it, herein lies the problem; managed care plans are designed to discourage patient utilization. What's more, practitioners must see large numbers of "plan" or "capitation" patients in order to make ends meet because capitation rates are painfully inadequate. In the Washington, D.C. area capitation rates have remained stagnant for over ten years while member premiums have steadily increased.

In addition to Washington, D.C., my colleagues across the country have experienced discrimination and have also been forced to make major adjustments in the way they practice dentistry:

IN LOS ANGELES:

One provider was denied acceptance into an L.A. dental HMO as recently as three months ago when a new CIGNA HMO for the L.A. teachers replaced the previous indemnity plan. This plan enrolled thousands of suscribers in black communities, but did not market African American dentists. Some doctors have been put on waiting lists, but their patients have already been reassigned to a "plan" dentist and patients are not offered an <u>equitable</u> alternative. California law mandates provider choice, but patients are unaware of this because <u>only</u> the HMO is actively marketed.

In addition, general dentists are being penalized for referring to oral surgeons because money is deducted from their capitation checks each time they refer patients for treatment. There is no incentive to treat periodontal disease in advanced stages, because the reimbursement rates are so low that specialists cannot afford to treat these patients.

IN SOUTHERN MARYLAND:

Renumeration is so low that value-added services (like confirmation calls, early morning and late evening appointments, mailing recall cards, complimentary toothbrushes, etc.) are eliminated. The onus is placed on the patients to call in for periodic and preventive treatment. Renumeration can start as low as 45 percent on the usual customary fees. If there is any profit margin, it will depend on how well the office is managing the plan, how good a gatekeeper they are, how well they have reestablished their protocols and how much they have lowered their overhead.

In some cases (CIGNA Dental Health Care) actually reduced their capitation rates as well as lowered patient co-payments in order to underbid their competitors. The providers learned about these reductions after the decision was made and when the new fee schedules were mailed to them, which happens only once a year!

Frequently, the judgement of the provider is undermined when treatment decisions are made in the best interest of the patient, but the treatment may not conform to listed procedures and fees. In many situations, patients who misunderstand the nature of the treatment will call the plan's administrative office, speak to one of their staff members, and in turn a staff member may indicate--without any communication with the dental office--that the provider was out of order or should not have charged certain fees.

IN CHICAGO:

A patient lodged a complaint against the doctor who had been a plan provider for over ten years, and the plan administrators threatened to terminate the doctor even though her office had a very large patient enrollment. Minority providers have found that plan administrators usually resort to this tactic when they want to drop one doctor (usually a minority) in order to add another doctor, usually in another zip code. In that same city, one doctor applied to be a provider in the plan in 1989 and was wait listed and not invited to join that plan until three years later in 1992.

The Chicago Board of Education offers two dental plans. The HMO covers members and dependents, and the fee-for-service indemnity plan (Dental Care Plus) covers individuals only. According to Illinois state laws, subscribers DO have a choice of providers, but these choices are not being advertised or promoted. Instead they are hidden in fine print clauses of the contract and most subscribers are not even aware of their choices. Patients who do choose the fee-for-service plan receive care from dental providers who wait on an average of ninety to one hundred and twenty days for a claim to be paid. When one of my colleagues lodged a complaint with the Illinois Insurance Commissioner, the doctor was told that there was a state law in place to protect the patients--not the provider--and the law called for a response to the claim within thirty days, not necessarily payment.

IN PHILADELPHIA:

The majority of the Blue Cross/Blue Shield indemnity plans were recently converted to Blue Cross/Blue Shield HMO. One of the criteria for being a specialty provider in the HMO was that all specialists must be board certified. One of the Oral and Maxillofacial surgeons (oral surgeons) was told that he would not be able to provide care under the new HMO because he was board eligible, but not board certified. This doctor had been providing care under the BC/BS indemnity plan for over thirteen years with no grievances, complaints or any litigation. The doctor requested a meeting with the director of the BC/BS PPO at his office. Upon further evaluation of the issue, and reconsideration of the new criteria, the director reversed the previous decision and allowed the doctor to become a provider in the BC/BS HMO. However, had

this individual not pursued the matter on his own behalf, he would not have been allowed to participate.

It was also revealed that in two of Philadelphia's other dental plans (PRUCARE, the Prudential HMO, and the AETNA Health Plan PPO) no other oral surgeons are being allowed to participate. These plans have indicated that they have enough oral surgeons in the area, but NONE of Philadelphia's five black oral surgeons are in the plan, despite the fact that between 30-35 percent of the plan's subscribers are from the African American and other minority communities.

IN FLORIDA:

When managed care programs were started, widespread discriminatory practices were quite evident in the management of those programs. The networks were closed panels with few African Americans having access to the panel.

Today, managed care programs are more common and with easier provider access. However, with the fee schedules being pre-determined, non-negotiable rates which are generally insufficient to maintain a practice if the practitioner accepts more than 30 percent capitation, the provider is usually faced with a lose-lose situation. If he doesn't join managed care networks, then he stands to lose patients whom he had been treating for years. Those patients would usually elect to transfer to a network member due to pure financial reasons. If he does participate in numerous panel networks or if his managed care patients population is excessive, then he often times will compromise quality care delivery in order to make the program work. Needless to say, the patient or the doctor suffers while the managed care networks benefit.

The potentially positive aspects of Managed Care are already known. They include:

- Controls health costs.
- Employer mandated contributions are tax deductible.
- National Health Board would establish budget, oversee the overall implementation of the plan, and monitor states' compliance with guidelines establishing alliances and achieving full implementation by 1997.
- Lower out-of-pocket costs for patient.

The elements which may have negative impact on minority populations and which are causing us the greatest concern are:

- Exclusion of high risk populations.

- Exclusion and termination of African American providers, especially specialists.
- Dilution of provider pool.
- Arbitrary reassignment of patients.
- Dismantling of community-based private practice infrastructure.
- Disruption of continuity of care.
- Inadequate reimbursement for providers with patients who have multiple risk factors and accumulation of untreated disorders.
- "Red-lining" by zip codes in low income area.

The National Dental Association suggests that the following measures be taken:

1. Dental care must be considered as a primary care service--not an adjunctive service--and as such, must receive adequate and appropriate funding consideration.

2. Decrease the financial burden that small businesses will incur in paying for employees' health coverage by offering additional tax incentives and subsidies.

3. Take immediate steps to stem the tide of discrimination and exclusion that is confronting high risk patients and their providers which is escalating at an alarming rate in plans throughout the country. Develop mechanisms for minority ownership, leadership and control of managed care systems.

4. Establish dialogue with health legislators on a state and local level which will more effectively monitor the health plans in their jurisdiction with regard to the structure, composition (patient and provider profiles) and special provisions for high risk groups.

5. Modify anti-trust laws to allow for "collaborative managed care" where consumers, employers, providers, administrators and legislators can collaborate on services, fees, reimbursement rates, facilities and programs that will be beneficial to all.

6. Take the necessary course of action to preserve, expand and protect the community-based infrastructure and networks of essential providers.

7. Provide the federal funding necessary to create a new health work force that will include an increased number of African Americans and other minorities.

8. Take immediate steps to cooperate with the U.S. Public Health Service in identifying and designating medical and dental manpower shortage areas, especially in urban underserved areas.

9. Establish licensure reciprocity to allow health professionals the mobility to provide care and services in areas where it is needed most.

10. Use risk adjusted rates for high risk communities.

11. Expand the definition of primary care to include dental care.

12. Expand the definition of "essential community provider" to include dental practitioners in underserved areas.

13. Expand the definition of "gate keeper" to include general dentists.

14. Select culturally sensitive professionals to evaluate systems for quality.

15. Insist on the proportionate representation of African Americans on all governing, credentialing and quality assurance boards. This should include notification to all African American providers of any new managed care plan started in their area, including an invitation to join the plan.

Thank you giving us the opportunity to testify before this committee. Please call on us in the future if we can be of any further service to you.

Special thanks to the following for their input in the preparation of this testimony:

Chester A. Aikens, D.D.S.
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Loretta Gilmore, D.D.S.
Paul McLeod, D.D.S.
Franklyn Scott, D.D.S.

Mr. PAYNE. Ms. Hoshi-Bush. Did I say that correctly?

Ms. HOSHI-BUSH. Yes, you did. Thank you.

I would like to thank Congressman Payne and members of the Government Operations Subcommittee on Human Resources and Intergovernmental Affairs for the opportunity to represent the American Physical Therapy Association at this important hearing.

My name is Susan Hoshi-Bush. I am a licensed physical therapist and presently serving as director of physical medicine and rehabilitation at Mary Washington Hospital in Fredericksburg, VA, having previously practiced for 18 years in California.

As stated in APTA's Statement on Health Care Reform, which you have received today, two key issues of concern to all physical therapists in the debate, are: access to care and prevention. These issues have even more intensity when they involve minority physical therapists.

By sheer numbers, there exists a lack of access to minority physical therapists, as minorities compromise only 7 percent of graduates and 7 percent of those currently practicing physical therapy. Many choose to practice in rural or inner-city locations, which will likely have the most difficulties in making the transition to managed care.

A probable result of increased managed care will be the elimination of some facilities in underserved areas and patients could have to travel to facilities far from home. The APTA concurs with the Congressional Black Caucus Health Care Reform Statement which supports financial incentives for providers in underserved areas. We are concerned about the ability of minority therapists to participate in managed care networks.

Generally, minority therapists have small practices. They may not have the financial ability to be viable partners or compete for spots in the network. Demonstration programs for minority health care businesses which provide capital resources and administrative support should be included in reform.

We appreciate the inclusion of allied health professionals in a recommendation in the Congressional Black Caucus statement which would require a Government report on the inclusion and status of minorities in managed care organizations and the organization's performance on various quality measures by race and ethnicity.

Relating to prevention, physical therapy has essentially been excluded in all proposals in this area, even though this is a vital part of my profession. As enumerated in the APTA statement, we believe that an affordable package of restorative and preventive physical therapy services would result in significant cost savings for minority health problems.

Our prevention program must be culturally sensitive. A 1984 Heckler report shows that minorities in general—and blacks in particular—get sicker, get medical attention later, and die sooner than whites, often from preventable conditions. The major killers are: heart disease, cancer, stroke, infant mortality and low birthweight, diabetes, suicide and homicide, and substance abuse.

The Heckler report and subsequent studies by other entities have shown that while health status—the measure of life's quality—has improved for all Americans, it has improved less for blacks and

other minorities. Many of the above-mentioned conditions could be alleviated by the inclusion of a restorative and preventable physical therapy program as part of health care reform.

As previously stated, the number of minority physical therapy professionals is relatively small and more must be educated. Of the 138 accredited physical therapy programs in the United States and Puerto Rico, only 7 are predominantly minority institutions. The education of more therapists is an important part of the Disadvantaged Minority Health Improvement Act, but more assistance is needed.

Funding for physical therapy education is key to increasing the numbers of minority physical therapy professionals. The U.S. Department of Health and Human Services Bureau of Health Professions in its seventh annual report to the President and Congress on the status of health professions notes that the allied health field is faced with growing shortages of personnel in a number of critical areas and underrepresentation of minorities.

There are a number of provisions supported by the APTA in some of the health care reform proposals which would be particularly positive for minority providers and patients. First and foremost, health care reform must have the goal of universal coverage and access to health care for all Americans, regardless of economic status. Included in this must be a standard benefits package with comprehensive coverage for both inpatient and outpatient physical therapy. Every Member of Congress received a get well sooner card this week from the APTA reminding them about the cost-saving benefits of physical therapy.

Consumers should have the freedom to select among providers who are authorized and qualified by State law to provide covered professional health services. There should be an antidiscrimination clause which would not allow any State, health plan, or large employer to discriminate in participation or reimbursement against a provider who is acting within the scope of his or her license under the applicable State law.

Research would be an integral part of reform and include effectiveness studies to evaluate the outcomes of various modes of intervention. Factors such as race and ethnicity should be included in data collection.

As a physical therapist practicing in California and here in Virginia, I have had the opportunity to experience managed care both as a minority health care provider and as a patient.

I found the experience to be less than satisfactory. This system assumes that patients are knowledgeable about health care and how the system operates. If English is not the person's first language, as in the case for many California residents, there is a lack of understanding and care can be far from adequate.

Some of the frustrations I encountered included a breakdown of the continuity of care because insurance companies mandated, negotiated who, what, when, where, and how much health care is delivered; little followthrough of care because treatment may be delayed or performed by several providers, leading to possible adverse and costly effects, such as hospitalization; a system skewed toward the economically well-off; limited availability of clinics, particularly

in underserved areas, forcing patients to use providers miles from home.

I urge Congress to keep these problems in mind as the Members move toward the passage of health care reform. Again, I thank you for the opportunity to provide my views and those of the American Physical Therapy Association to the members of the subcommittee.

[The prepared statement of Ms. Hoshi-Bush follows:]

I would like to thank Chairman Towns and the members of the Government Operations Subcommittee on Human Resources and Intergovernmental Affairs for the opportunity to represent the American Physical Therapy Association (APTA) at this important hearing. My name is Susan Hoshi-Bush; I am a licensed physical therapist and presently serving as Director of Physical Medicine and Rehabilitation at Mary Washington Hospital in Fredericksburg, Virginia, having previously practiced for eighteen years in California. The APTA is a national professional association representing 62,000 physical therapists, physical therapist assistants and students of physical therapy.

PROPOSED HEALTH CARE REFORM CONCERNS

As stated in the APTA's "Statement on Health Care Reform" which you have received today, two key issues of concern to all physical therapists in the health care reform debate are access to care and prevention. These two issues have even more intensity when they involve minority physical therapists.

By sheer numbers, there already exists a lack of access to minority physical therapists -- only 7% of the physical therapists who graduated from physical therapy programs in 1992 were minority students. Many choose to practice in rural or innercity locations, which will likely have the most difficulties in making the transition to managed care. With the probable result of increased managed care being the elimination of some medical facilities in these areas, patients could lose their access to providers and be forced to use facilities miles from home. The APTA concurs with the Congressional Black Caucus Health Care Reform Statement which supports financial incentives for providers who practice in underserved areas.

Also, we are concerned about the ability of minorities to participate in managed care networks for two other reasons: financial and racial. Generally, minority physical therapists have one or two person practices, so these small businesses would not have the financial ability to be viable business partners or compete with others for spots in the network and would likely be bought out. At the very least, demonstration programs for minority health care businesses which would provide capital resources and administrative support should be included in health care reform. In addition, we appreciate the inclusion of allied health professionals in a recommendation in the Congressional Black Caucus statement which would direct the Secretary of the Department of Health and Human Services to provide a report on the inclusion and status of minorities in managed care organizations and the organizations' performance on various quality measures by race and ethnicity. We strongly concur with this recommendation.

In terms of race, minorities have unique health problems which may not be addressed by a system that limits the number of treatment sessions, does not allow a patient to go outside the system for specialized care, and may force a patient to wait weeks to receive care. One American in five is black, Hispanic/Latino, Native American, or Asian/Pacific Islander. In states such as California, where I worked, the early part of the next century will see minority populations exceed the white population. These four groups, along with immigrants, have different cultures, languages, and health problems, all of which have important implications for health program planning and design, which are not adequately taken into account in the present health care reform proposals.

Relating to prevention, the profession of physical therapy has essentially been excluded in all the health care reform proposals in this area, even though this is a vital part of my profession. As enumerated in the APTA statement, we believe that an affordable package of restorative and preventive physical therapy services would result in significant cost savings. Such a package should include the following:

- Low back pain prevention and intervention programs;
- Industrial health programs;
- Osteoporosis and arthritis intervention programs and programs aimed at decreasing falls in the elderly;
- Cardiac and pulmonary rehabilitation programs;
- Prenatal and postpartum intervention programs;
- Health promotion programs;
- Programs aimed at addictive behaviors or violence.

For minority health problems, a prevention program should be culturally sensitive. The first federal report on minority health problems came in 1984, with the Heckler report, a seven-volume study showing that minorities in general -- and blacks in particular -- are sicker, get medical attention later, and die sooner than whites, often from preventable conditions. The major killers are: heart disease, cancer, stroke, infant mortality and low birthweight, diabetes, suicide and homicide, and substance abuse. The Heckler Report and subsequent studies by other entities have shown that while health status -- the measure of life's quality -- has improved for all Americans, it has improved less for blacks and other minorities. Many of the above-mentioned conditions could be alleviated by the inclusion of a restorative and preventive physical therapy program as part of health care reform.

Our final concern is the lack of funding for physical therapy education, which would increase both student and faculty numbers, in any of the health care reform proposals. This is particularly necessary for increasing minority representation in these two areas. There are currently 138 schools which offer accredited programs in physical therapy in the United States and Puerto Rico. Of these, only seven are predominantly minority institutions -- Howard University, Florida International University, Florida A & M University, Langston University, University of Maryland/Eastern Shore, University of Puerto Rico and Tennessee State University. Of all the 1992 graduates from physical therapy programs, only 7% were minority students and only 9% of the faculty that taught them were minorities.

Also, the number of minority professionals providing physical therapy and other rehabilitation services is relatively small. For instance, there are approximately 4,500 minority physical therapists in the United States, only 7% of the total. Therefore, more minority professionals must be educated. The education of more therapists is an important part of the Disadvantaged Minority Health Improvement Act, but more assistance is needed. Funding for the preparation of therapists and other providers is key to increasing the numbers of minorities in the rehabilitation field. Therapists not only provide service to minorities with disabilities, they are vital in providing education on prevention of disabling conditions. The United States Department of Health and Human Services' Bureau of Health Professions, in its Seventh Annual Report to the President and Congress on the Status of Health Personnel notes that "...the allied health field is faced with growing shortages of personnel in a number of critical areas ...(and)...underrepresentation of minorities..". It cites a tremendous increase in demand for physical therapist (57%) between now and the year 2000.

PROTECTIONS FOR MINORITY PROVIDERS AND PATIENTS

There are a number of provisions supported by the APTA in some of the health care reform proposals which would be particularly positive for minority providers and patients. First and foremost, health care reform must have the goal of universal coverage and access to health care for all Americans, regardless of economic status. Included in this must be a standard benefits package with comprehensive coverage for both inpatient and outpatient physical therapy. Every member of Congress received a "Get Well Sooner" card this week from the APTA reminding them about the cost-saving benefits of physical therapy. The benefits have been verified by a number of studies including one conducted by the Health Insurance Association of America of member companies which reported a savings of $11 for every $1 spent on rehabilitation with a savings per claimant ranging from $1500 to over $250,000.

Second, consumers should have the freedom to select among providers who are authorized and qualified by state law to provide covered professional health services. To ensure this, there should be an antidiscrimination clause which would not allow any state, health plan, or large employer to discriminate in participation, reimbursement, or indemnification against a provider who is acting within the scope of his or her license or certification under applicable state law. Further, an any willing provider clause would enhance consumer choice and afford minority health care providers greater opportunities to participate in health plans.

Third, because of the location of many minority patients in rural and underserved urban areas and because of its cost-effectiveness, home and community-based services should be offered

as an alternative to institutional services for the provision of long-term care. Eligibility for these services should include the inability to ambulate for sufficient duration and distance and should also include respite care.

Finally, research should be an integral part of health care reform and include effectiveness studies to evaluate the outcomes of various modes of intervention. Data collection should take into account the following factors: race, ethnicity, national origin, sex, language, income, age and residence.

PERSONAL EXPERIENCE

As a physical therapist practicing in California, I had the opportunity to experience managed care both as a minority health care provider and patient; I found the experience less than satisfactory. The system assumes that patients are knowledgeable about health care and how the system operates. If English is not a person's first language, as is the case in California with many Hispanic and Asian residents, there is a lack of understanding and care can be far from adequate. Some of the frustrations I encountered included:

- Breakdown in the continuity of care because insurance companies mandated/negotiated who, what, when, where and how much health care is delivered;
- Little follow-through of care because treatment may be delayed or performed by several providers, leading to possible adverse and costly effects such as hospitalization;
- A system skewed toward the economically well-off, with patients more likely to be seen by providers many times if they can make a co-payment;
- Limited availability of clinics, particularly in the underserved areas, forcing patients to use providers or hospitals miles from home;
- Vast amounts of documentation and paperwork.

Obviously, this is not the kind of health care system that would be very beneficial to minority patients or provide many opportunities for minority practitioners. I urge Congress to keep these problems in mind as the members move toward the passage of health care reform.

Again, I thank you for the opportunity to provide my views and those of the American Physical Therapy Association to the members of the Subcommittee and would be happy to answer any questions you might have.

Mr. TOWNS. Thank you very much. Mrs. Tompkins?

Ms. TOMPKINS. Chairman Towns, Mr. Payne, and others of the Subcommittee on Human Resources and Intergovernmental Relations, thank you for the opportunity to testify on behalf of the over 70 chapters of the National Black Nurses Association, and our national president, Dr. Linda Burns Bolton from the State of California.

Before I summarize the written statement of NBNA, I would like to say that I am just fresh from a meeting of our organization, our 22nd annual institute and conference which was held just this past week in Las Vegas, NV, where we had over 1,200 members and family and friends attend around the theme of restructuring the health care reform system within the United States. So that you can see that for African-American nurses, this is a very important issue. That was the largest conference, in attendance, that we had ever had and it came about around this particular issue.

The National Black Nurses Association is committed to universal access to and utilization of comprehensive health services; funding of innovative approaches to improve the health status of all Americans; support for undergraduate and graduate nursing education; outcomes monitoring and evaluation; building of the public health infrastructure and reimbursement for nurses.

The major elements of our concerns are as follows: It is essential that universal access to and financial coverage for a standard comprehensive benefits package be provided. Universal access must include access to culturally competent health providers who live and work in the communities they serve. We believe that both public and private funding must be provided to make this happen.

The NBNA supports funding for innovative programs to reduce health status disparities between population groups. We believe that essential community providers, in partnership with community residents, are more likely to develop and implement effective health programs.

Support for health services research conducted by nurses and other providers is also essential.

Health promotion and disease prevention for all populations in all geographical areas must be aggressively addressed in order to eliminate the glaring disparities that now exist. A reform health care system must emphasize both preventive and curative services, including maternal and child health, mental health, dental health, immunizations, family planning, cancer screening, sexually transmitted disease care, and programs for children with special health care needs, which many times in many programs are delivered by nurses in public health programs.

Programs are needed to provide community-based, long-term care services for people with severe disabilities, and the severely mentally ill and technology-dependent children. Many of these numbers are swelled because of this past decade when we have had an increase in violence, substance abuse, and HIV disease.

In a reformed health care system, hospitals will serve primarily to meet acute care needs. Other sites, such as school-based, workplace-based, and community-based centers should be developed to deliver primary and preventive care. Funding for Public Health Service education must continue to ensure that nursing profes-

sionals can continue providing the public health programs that support the health care needs of some of this Nation.

To increase diversity of the health care work force and ensure an adequate supply of providers in underserved areas, support is needed for programs to increase the number of health professionals among culturally and ethnically diverse groups.

Nurses at all levels must be prepared to meet the health needs of culturally diverse populations. Meeting the increased demand that is anticipated to result from universal access will prepare adequate numbers of appropriate health care providers at many levels. A reliable source of funding for nurse education is integral in effective health care reform. Nurses must play a meaningful leadership role in developing and implementing new models of care to ensure quality health and illness services for all Americans.

We also want to point out, and just to try to pull my remarks to a close, that when we talk about quality, we are talking about cultural competency. Quality of care cannot be looked at without looking at cultural competence, cultural sensitivity, and cultural diversity.

Thank you for the opportunity to make these remarks.

[The prepared statement of Ms. Tompkins follows:]

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TESTIMONY

Hearing Can Minority Providers Survive Health Care Reform?
Congress of the United States, House of Representatives, Committee on Government Operations, Subcommittee on Human Resources and Intergovernmental Relations
Rayburn House Office Building
Room 2247
Friday, August 5, 1994

The National Black Nurse's association (NBNA) is a professional organization of registered nurses, licensed vocational/practical nurses and nursing students The mission of NBNA is to investigate, define and determine what the health needs of African Americans are and to implement change to make available to African Americans and other minorities health care commensurate with that of the larger society. The National Black Nurse's Association represents over 150,000 African American Nurses and has over 23 years of commitment and dedication to quality health care for all Americans. African American Nurses are essential to the health of this nation .

Thousands of us serve on front lines providing direct primary care in Emergency Rooms, City Hospitals, neighborhood health centers and the like to the close to 40 million Americans who are without health insurance and, have no primary care providers The poor , the minority many of whom are African American are plagued by the most serious and preventable of diseases such as HIV Disease, Tuberculosis, Heart Disease and stroke These same Americans give birth to thousands of low birth weight babies and babies who die during the first year of life.

The National Black Nurses Association is committed to universal access to and utilization of comprehensive health services; funding of innovative approaches to improve the health status of all Americans; support for undergraduate and graduate nursing education, outcomes monitoring and evaluation; building of the public health infrastructure and reimbursement for nurses.
The NBNA stands ready to lead a Renaissance of Caring to build the nation's capacity to bring about desired health outcomes This renaissance focuses on the following.

Universal Access and Coverage
It is essential the universal access to and financial coverage for a standard comprehensive benefit package be provided. Universal access must include access to culturally competent health providers who live and work in the communities they serve. We believe that both public and private funding must be provided

Innovative Approaches
The NBNA supports funding for innovative programs to reduce the health status disparities between population groups. We believe that essential community providers in partnership with community residents are more likely to develop and implement effective health programs. Support for health services research conducted by nurses and other providers is essential.

Public and Community Health
In order to build a healthier America, a reformed health care system must address health promotion and disease prevention for all populations in all geographic areas

A reformed health care system must emphasize both preventive and curative services, including maternal and child health, immunizations, family planning, cancer screening , sexually transmitted disease (STD) care, and programs for children with special needs, which are delivered by nurses in public health programs.

Programs are needed to provide community -based long-term care services for people with severe disabilities, the severely mentally ill, and technology-dependent children

In a reformed health care system, hospitals will serve primarily to meet acute-care needs Other sites, such as school-based, workplace-based and community based centers, should be developed to deliver primary and preventive care

Funding for Public Health Service education must continue, to ensure that nursing professionals can continue providing the public health programs that support the health care needs of much of the nation

To increase diversity of the health care work force and ensure an adequate supply of providers in undeserved areas, support is needed for programs to increase the number of health professionals among culturally and ethically diverse groups

Nursing Education
Nurses at all levels must be prepared to meet the health needs of culturally diverse populations Meeting the increased demand that is anticipated to result from universal access will prepare adequate numbers of appropriate health care providers at many levels A reliable source of funding for nurse education is integral to effective health care reform
Nurses must play meaningful leadership roles in developing and implementing new models of care to ensure quality health and illness services for all Americans Federal support for educating advanced practice nurses would help the nation meet the increased demand for cost-effective providers for high-quality primary care
Nurses with advanced education are becoming an increasing part of the solution to problems of access, quality of care, and cost-effectiveness. In an era of scare resources, it is essential to invest in ensuring the continuation of nursing's unique contributions to the health of the nation

Monitoring and Evaluation
The proposed Health Report Cards will play an important program evaluation role We must examine clinical and functional status of individuals, provider competency, client satisfaction, health care utilization and financial outcomes measures Providers and consumers must be accountable for designing effective systems

Reimbursement for Advanced Practice Nurses Under Medicare and Medicaid
Under current law, Medicare and Medicaid provide direct reimbursement to advanced practice nurses only in limited cases These limitations are arbitrary and should be abolished, providing direct reimbursement equally to all advanced practice nurses.

As cost-effective sources of quality care, advanced practice nurses can enhance patient's access to vital care, particularly in undeserved rural and urban areas Registered nurses make access to health care affordable, available, acceptable and accountable. In many cases, The Health Care Financing Administration is already paying for the services of advanced practice nurses, but is paying through physicians and therefore is paying at physician rates In these instances, direct reimbursement will save money, at least 15 percent

Workforce Issues
Quality of care is the single most overlooked issue in the current debate Yet quality is what every American cares about most. It is the most important standard by which health care reform will be measured And the quality of care Americans receive in hospitals and other settings is directly related to the services provided by registered nurses Heath care reform must guarantee quality nursing care to all

By the year 2005, our nation will need-- not fewer nurses-- but three quarters of a million more nurses than we have today Remembering the consequences of the severe nursing shortage of the mid-1980's, we must not let that happen again. If we are going to attract the bright, committed young people we will need in ten years, nursing must continue to be regarded as a valued profession offering challenges and opportunities for career growth.
NBNA supports the development of an Institute for Health Care Workforce Development to oversee skill upgrading and occupational retraining to support nurses-- and all health care workers-- in assuming their essential and varied roles in the new health care system

Mr. PAYNE [presiding]. Thank you very much.

Mr. King.

Mr. KING. Congressman, thank you for the opportunity to be here. I am a member of the National Association of Medical Equipment Services.

Mr. PAYNE. Would you mind speaking into the mike? Maybe you can pull it over to you a little bit more.

Mr. KING. I am a member of the National Association of Medical Equipment Services, and I have been a Medicare provider with majority ownership of Community Home Medical, Inc., for over 5 years.

CHM is accredited by the Joint Commission on Accreditation of Health Care Organizations for Clinical Respiratory Home Care and Home Medical Equipment Management. The first question Congressman Towns addressed to me was regarding the proposed health care reform legislation and my opinion as to how it will affect minority providers. My concern is minority suppliers who will be contracted to bid on Medicare and HMO contracts; second, what qualifications will be required of those bidding to fill the needs of the patients for those systems of respiratory therapy and durable medical and mobility equipment.

In a competitive low-bid winner-take-all scenario, I believe that minority and small providers will not be on an equal footing to bid. I believe this low-bid-only method would also cause the patients to have tremendous reinfection rates, higher hospitalization rates, and poor compliance with most plans of treatment that their physicians have prescribed for them to use in the home.

I was contacted by mail from a large northern California HMO in 1991 by their minority outreach program. They requested all sorts of information listing a board of directors, licensing, proof of minority status, recent profit and loss statements and each requested a picture I.D. to substantiate minority status. Although I spoke with them by phone to discuss my company and spent much time to provide all of their requested information, when it came time to bid in 1994, I was not even contacted to participate. By the time I called the HMO, they had awarded the contracts to one national company and one regional company. Neither the regional provider nor the national provider have the accreditation level of my company.

Managed care plans today often contract with the largest, lowest bidder they can find without regard to the quality of services. For example, a recent HMO merger caused the forced change of services for an elderly woman who had been a client of Community Home Medical for about 3 years. She sent a copy of her letter to her HMO in 1993 and again to me in July 1994, voicing her concerns about these changes in health care.

This client is stable and currently productive with her family and community under our care, but her new HMO carrier has changed her provider of service, eliminating her right to choose. And although she has said by phone and letter that she wishes to stay with CHM, she is afraid she will lose her only health coverage if she fights too hard for her preference.

The second question to me was to address what protections for minority providers in your opinion should be included in the health

reform bill. One remedy would be to establish a due process for bidding on health care contracts. This involves public notice and open process, which is based on the ability to provide accredited equipment or care to ensure patient safety. The standards should be included as prerequisites for bidding eligibility. In this manner all qualified providers may bid and hopefully more than single bid winners will be awarded as that brings competition to the table.

Another protection for small and minority businesses would be to expedite payment for Medicare, at least require carriers to meet the payment deadlines required by congressional law. CHM has claims held by Medicare carriers for greater or in excess of $138,000 for 60 days in excess of $100,000. This is just under 10 percent of our gross annual revenue. This impacts tremendously a small or minority-owned business.

Banks look at U.S. Government receivables as discounted because they take so long to pay. In fact, Medicare carriers may get increased administrative costs incentives to reprocess claims. I believe it would be helpful and cost-effective to make the contracts, Medicare carrier contracts public information, so that Medicare carriers could be held to a standard for fraud and abuse along with health care providers.

Your third request was for a response regarding additional personal account for discriminatory practices when dealing with health maintenance organizations or any health care-related organizations. A significant inequity which could be rectified by a simple regulation adjustment regards payment by Medicare for respiratory care in skilled nursing facilities.

Under current regulation, a hospital can hire out their respiratory care practitioners to do therapy and be paid part A Medicare in a skilled nursing home outside the hospital. This occurs even though those therapists or the hospital have no accreditation in clinical respiratory care outside the acute care setting.

On the other hand, my company, even though we have joint commission accreditation and we are an entity for clinical respiratory care outside the acute setting, cannot charge Medicare for therapist treatments in skilled nursing facilities. A patient may have been a patient of ours and not be allowed to get care.

In closing, I would like to say, as noted recently and stated best in the July/August 1994 Harvard Business Review, the United States can achieve universal access and lower costs without sacrificing quality, but only by allowing competition to work at all levels of the health care system. I am asking you to give me the chance to compete.

[The prepared statement of Mr. King follows:]

Testimony of
Robert W. King, President/Chief Executive Officer
Community Home Medical
Grass Valley, California
and
Representing the
National Association for Medical Equipment Services
on
The Impact of Health Care Reform on Minority Providers

Hearing
of
Friday, August 5, 1994

Before the
House Governmental Operations Subcommittee
on Human Resources and Intergovernmental Relations

On behalf of the National Association for Medical Equipment Services (NAMES), I am pleased to have this opportunity to comment on the possible impact of national health care reform legislation on minority health care providers. I am Robert W. King, President and CEO of Community Home Medical in Grass Valley, California. My company provides a full range of home medical equipment (HME) services and products, including oxygen therapies, and helps take care of approximately 200 patients and consumers per month who reside within a 75 mile radius of my company's location.

NAMES membership comprises over 2,000 HME companies such as mine, which provide quality, cost-effective services to consumers in the home. These companies take pride in providing personal, comprehensive HME services in the home, where the vast majority of individuals prefer to recuperate. HME consists of basic aids for daily living and a vast array of highly specialized and advanced services, such as oxygen and ventilator systems; infusion therapy for the provision of antibiotics and chemotherapy; wound care and ostomy supplies; and advanced rehabilitation equipment and assistive technology.

Overview

The HME services industry is extremely concerned about the negative impact two health care reform proposals would have on small, independent minority-owned HME companies if implemented: (1) competitive bidding for oxygen and oxygen equipment; and (2) "single source" managed care contracts, where managed care organizations (such as HMOs or PPOs) would be permitted to contract with only one health care provider in a given field.

I. Competitive Bidding

The Senate Finance Committee's health care reform plan contains a provision that requires "competitive bidding" for oxygen and oxygen equipment under the Medicare program. That plan also would allow the Secretary of Health and Human Services (HHS) to competitively bid "other such items and services" as deemed appropriate. Further, the Secretary of HHS would be permitted to award just one oxygen contract to an HME provider in a given geographic area, thereby allowing that single company to provide all the oxygen services to every Medicare beneficiary living in that area.

Essentially, competitive bidding under the Senate Finance plan would establish a "winner take all" situation. Unfortunately, the eventual winner in such a competitive bidding system likely would be the lowest bidder, and not necessarily the HME supplier who provides the best services at the most cost-effective price. Unsuccessful HME companies — those which do not win the bid — would be prevented from participating in the Medicare program for the provision of oxygen and oxygen services under this plan. The Department of Veterans Affairs and Medicaid programs in a few states currently award contracts for oxygen equipment in this manner. Reports to NAMES regarding the poor servicing, repair and maintenance of home medical equipment under these systems are plentiful.

Currently, over 80% of the recipients of oxygen services and equipment are Medicare beneficiaries.[1] More than 40% of an average HME supplier's revenues are derived from providing oxygen services and respiratory therapy; for some companies, their entire revenue is derived from oxygen and respiratory therapy. If such a company fails to win the Medicare competitive bidding contract, they most likely will be forced to go out of business.

While small HME businesses may very well undergo marked discrimination in a competitive bidding environment because of their size, I believe this situation may be particularly problematic for small, independent minority-owned businesses. Given that discrimination against women, people of color, and ethnic or religious groups still exists in our society, minority-owned HME companies certainly would be at even further risk under such a competitive bidding scheme. For minority-owned HME companies which lose a contract today because of discriminatory practices, the economic impact certainly is felt. But if those same companies also lose their ability to provide HME and oxygen services under the Medicare program, the resultant effect would be devastating.

Fortunately, Mr. Chairman, the health care reform plan that is being proposed by House Majority Leader Richard Gephardt (D-MO), like the House Ways and Means Committee package it was forged from, does not contain competitive bidding for oxygen or other home medical equipment. We hope the final House bill also leaves this particularly adverse policy on the cutting room floor.

II. "Single Source" Contracts

Managed care has infiltrated today's health care market. On the surface, the potential for cost containment under managed care looks appealing. Individuals and companies are being encouraged to join managed care plans. Those managed care plans, in turn, sometimes contract with just one company, a "single source," to provide all health products and services necessary for a specific benefit.

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[1] National Association of Medical Equipment Suppliers, 1993 Industry Survey, July 1993, Exhibit.

The Health Security Act specifically encourages managed care plans to contract with only one company in a given field. Managed care contracts of this nature would operate like and have similar effects to the above-described competitive bidding scheme proposed for the Medicare program. The only difference is that competitive bidding would be implemented by the Federal Government for Medicare, and the "single source" provision would be implemented by the health plans.

"Single sourcing" would severely limit a consumer's option when choosing a health care provider. Many states currently prohibit "single source" arrangements due to the negative effects on consumer choice and qualified providers who are prohibited in area plans. If all Americans are economically encouraged through the Health Security Act to switch to managed care plans, our fear is that most consumers will. For me, as an HME supplier, this means that I must bid and then win the managed care contracts offered to consumers through their health plans. If I do not, most likely I will go out of business. Just as I described above in the scenario with competitive bidding, discriminatory bidding practices will have a particularly harmful impact on minority-owned business.

III. Minority Providers

Focusing on the impact of health care reform specifically on minority providers is difficult for me because, although I am a minority provider, I am first and foremost a small, independent businessman. However, I do realize that, as an African-American businessman, I am faced with several concerns that are not applicable to non-minorities in the health care provider community.

My specific concerns revolve around managed care plans and the process by which those plans will contract with HME suppliers once we have national health care reform. Managed care plans are very selective when choosing providers with whom to contract. However, when HMOs and other managed care entities begin their contracting processes, nothing dictates precisely who they must contact to solicit bids; neither are they required to have a set of qualifications, such as accreditation, to guide them in their selection process.

Managed care plans today often contract with the largest, lowest bidder they can find — without regard to quality or services. For example, my company has treated an elderly woman requiring oxygen equipment and ventilation for the past four years. With changes in her HMO contractor, I no longer am allowed to provide care for her. However, because this woman's HMO cannot provide the specialized care she needs, she now is in danger of being institutionalized — at a far higher cost for the government than if I were permitted to continue providing her care! Unfortunately, this "selective" scenario also helps set the stage for those managed care plans which covertly discriminate on the basis of race, religion, sex, or other factors, because the managed care company can simply choose with whom to contract right from the beginning.

What protection for minorities should be included in health care reform to prevent such outward discrimination? Congress must pass a health care bill that opens the bidding process to those providers who meet establish criteria and wish to submit a bid. Managed care companies then would be required to abide by this law by placing public announcements as to the process, timing and qualifications required. While this will not completely eliminate discrimination, it will establish the ground rules and allow equal opportunity for all. A further step to consider is due process for bidding on health care contracts. Specific regulations describing who may participate in the bidding and what qualifications are required for quality of care must be established. All plans should have to advertise publicly their requests for bids for contracted services.

When addressing the question of discriminatory practices that have happened specifically to me, I am reminded of one particular incident in which an HMO contacted me by mail in 1991. Apparently the company was trying to implement a "minority outreach" program. But after providing this company with all of the appropriate material, including a picture I.D. to substantiate my minority status, I still was

excluded from the health care plan. I subsequently discovered that two non-minority owned companies were selected. My company was notified as well that primary paid patients within a certain metropolitan area would not be paid by the HMO unless they received equipment or service from a company that was approved in the bid process.

Mr. Chairman, Members of the Committee, I could sit here and tell you that I have had to work twice as hard as my counterparts to succeed in my company but, as I stated above, I am first and foremost a businessman. In Northern California, where I live and work managed care organizations are upon us. The adjustments that I have made are not unlike others. The most detrimental effect that could be inflicted upon my company would be exclusion from a health care plan because of anti-competitive discrimination. I need the reassurance that I will be given equal rights to compete on a level playing field with other HME service companies.

If a competitive bidding or "single source" provision is included in national health care reform, it would eliminate most, if not all, minority providers. As noted recently and stated best in the July-August 1994 Harvard Business Review, "The United States can achieve universal access and lower costs with out sacrificing quality, but only by allowing competition to work at all levels of the health care system." I am asking you to give me the chance to compete.

Mr. PAYNE. Thank you very much. Dr. Torres.

Ms. TORRES. Thank you for the opportunity to address you today. My name is Blanche Torres. I am the sister of Dr. Sarah Torres and I am speaking on her behalf.

Mr. PAYNE. Thank you. Would you pull the mike over a little bit more in front of you?

Ms. TORRES. Yes. Sarah Torres has been a registered nurse for 23 years. She is currently a professor at the University of North Carolina in Charlotte, NC, where she chairs the Department of Community Health, Psychiatric Mental Health and Nursing Administration in the College of Nursing. She is also the president of the National Association of Hispanic Nurses, NAHN, an organization comprising 24 chapters representing 28,000 Hispanic nurses in the United States.

The major goal of the association is to improve the health care needs of the fastest growing segment of the U.S. population, and to provide equal access to educational, professional, and economic opportunities for Hispanic nurses.

The National Association of Hispanic Nurses has two major concerns regarding the impact of proposed health care reform legislation and its effect on Hispanic-Latino nurses as providers. One, the special needs of underserved Hispanic-Latino communities; and two, the crucial need for an increased number of Hispanic-Latino nurses.

First, the special needs of Hispanic-Latino underserved communities. Lack of culturally and linguistically appropriate services leave health care providers to serve multiple roles: For example, as nurse, interpreter, and perhaps even the Hispanic client's only source of contact. Bilingual, bicultural nurses are not compensated for additional services rendered such as translation, case management, although these are clearly necessary for adequate care, and they are often placed in the dilemma of choosing between personal responsibility and professional liability.

For example, one member of the NAHN was asked to give instructions for home care to a Hispanic family whose child was scheduled for discharge from the hospital. After talking with the family, the nurse found out that the child was recently diagnosed with myasthenia gravis, a complex neuromuscular disease that involves a complicated medication regimen and careful monitoring of the child's activity. However, no instruction had been given to the family prior to this time, because a translator was not available or had not been sought for this family.

The expectation was that the nurse would simply instruct the family so that the family could be discharged that day. No written instructions were available in Spanish, making it impossible to provide written instructions to the family. In light of the complexity of the instructions needed and the potential liability of the hospital and the nurse, the discharge of this family would have been clearly unsafe, since the nurse was unable to give the family instruction, and therefore, she would therefore not document that instruction had been given. Despite the expressed concerns of the nurse to the supervisor and the physician, the family was discharged and the nurse was reprimanded by her for failing to document that instruction had been given.

We must ensure that health providers are able to deliver their health messages to people in terms that they can understand, accept, and ultimately act upon. Accomplishing this requires understanding and respect for the background and cultural orientation of the people being served.

Health care providers must be culturally competent in order to work with patients' belief systems, family support systems, and alternate health care providers, such as the Hispanic-Latino curandero, and thereby, to provide truly adequate health care to Latino patients.

I will highlight two of the recommendations made by the association. One would be No. 2 in the handouts.

The plan must have Federal mechanisms to provide incentives, perhaps tied to reimbursement for culturally competent treatment providers in underserved areas. And No. 3, in order to create equal opportunity for Hispanic-Latinos in the use of health services, a health reform plan must prohibit race and national origin discrimination at the National Health Board, alliance, health plan, and provider levels. A health reform plan must also provide for Federal civil rights monitoring, data collection, and enforcement of remedies to ensure that any possible discrimination is detected and eliminated.

The second concern is the need for Hispanic nurses. The Hispanic-Latino nurses have not reached the expected representation based on our population. This is due to the paucity of opportunities for Hispanics to enter nursing and the need for more economic support, role models, and mentors for Hispanics in nursing schools not only during their education, but also during the early stages of career development.

The Hispanic-Latino community needs to achieve equity in nursing. According to the 1990 census, the Hispanic population in the United States is 9 percent. However, Hispanic nurses make up 1.4 percent of nurses in the United States, of whom 0.01 percent have doctoral degrees, 5 percent have master's degrees, 38 percent have associate degrees, 26.4 percent have bachelor's degrees, and 29.9 percent have diploma degrees. With only about 45 doctorally prepared Hispanic-Latino nurses in the United States, there is a dearth of Hispanic nurses educated to assume leadership roles in the delivery of health care to Hispanics.

I would just like to make two recommendations in this area: identify and secure equitable distribution of funds for improvement, retention, and career mobility of Hispanic Latinos in nursing and to increase the participation of Hispanic-Latino nurses at the decision-policymaking level.

For additional information, you would have to contact Dr. Sarah Torres, president of the National Association of Hispanic Nurses.

[The prepared statement of Ms. Torres follows:]

NATIONAL ASSOCIATION OF HISPANIC NURSES
1501 Sixteenth Street NW, Washington, DC 20036 • (202) 387-2477 fax 202.797.4353

August 5, 1994

The Honorable Edolphus Towns, Chairman
Subcommittee on Human Resources and
Intergovernmental Affairs
U.S. House of Representatives
Washington, DC

Dear Sir:

On behalf of the National Association of Hispanic Nurses, I would like to thank you for inviting us to participate in this important forum. We appreciate the opportunity to contribute and present our strategies on The Impact of Health Care Reform on Minority Providers. This effort provides a unique opportunity for providers to exchange ideas, share new findings, and work together to promote better opportunities for Hispanic patients and providers.

Sincerely yours,

Sara Torres

Sara Torres, RN, Ph.D., FAAN
President

The Impact of Health Care Reform on Minority Providers

Mr. Chairman and Subcommittee Members:

Thank you for inviting me to share my views on The Impact of Health Care Reform on Minority Providers. My name is Dr. Sara Torres. I have been a registered nurse for 23 years. Currently, I am a professor at the University of North Carolina in Charlotte, North Carolina, where I chair the Department of Community Health, Psychiatric/Mental Health and Nursing Administration in the College of Nursing. I am also President of the National Association of Hispanic Nurses (NAHN), an organization comprising 24 chapters, representing 28,000 Hispanic nurses in the United States. The major goal of the association is to improve the health care delivery needs of the fastest-growing segment of the U.S. population - the Hispanic community - and to provide equal access to educational, professional, and economic opportunities for Hispanic nurses.

The National Association of Hispanic Nurses has two major concerns regarding the impact of proposed health care reform legislation and it's effect on Hispanic/Latino nurses as providers: the special needs of underserved Hispanic/Latino communities and the crucial need for an increased number of Hispanic/Latino nurses.

Special Needs of Hispanic/Latino Underserved Communities

Lack of culturally and linguistically appropriate services leave health care providers to serve multiple roles, for example, as nurse, interpreter, and perhaps even the Hispanic client's only source of contact. Bilingual/bicultural nurses are not compensated for additional services rendered, such as translation and case management, although these are clearly necessary for adequate care, and they are often placed in the dilemma of choosing between personal responsibility and professional liability.

For example, one member of our association (NAHN) was asked to give instructions for home care to a Hispanic family whose child was scheduled for discharge from the hospital. After talking with the family the nurse found out that the child was recently diagnosed with

Myasthenia Gravis, a complex neuromuscular disease that involves a complicated medication regimen and careful monitoring of the child's activity. However no instructions had been given to the family prior to this time, because a translator was not available, or had not been sought for this family. The expectation was that the nurse would simply instruct the family so that the family could be discharged that day. No written instructions were available in Spanish, making it impossible to provide written instructions to the family. In light of the complexity of the instructions needed and the potential liability of the hospital and the nurse, to discharge this family would have been clearly unsafe, since the nurse was unable was to give the family instruction and therefore would not document that instructions had been given. Despite the expressed concerns of the nurse to the supervisor and physician, the family was discharged and the nurse was reprimanded by her supervisor for failing to document that instructions had been given.

We must ensure that health providers are able to deliver their health messages to people in terms that they can understand, accept, and ultimately act upon. Accomplishing this requires understanding and respect for the background and cultural orientation of the people being served. In order for health reform to be effective in underserved communities, it must be directed by providers from these communities. With respect to nursing, this statement is irrefutable. In a primarily Spanish-speaking neighborhood such as San Antonio, a nurse practitioner who is fluent in Spanish is able to see many more patients per day than a non-Spanish-speaking provider. Also, community-based nurses have greater knowledge of the community's health needs and a greater investment in the health of the community, compared to non-community-based nurses.

Health care providers must be familiar with their Hispanic/Latino patients' attitudes about medical conditions and disease prevention, in order to deliver high quality care and positively affect their patients' health-related behavior. It is common for Hispanic/Latinos to have beliefs and values regarding their health that are different from Anglo-American

beliefs and values and those of other cultures. Also, many Hispanic/Latino patients seek advice and care from alternative providers within their community.

Health care providers must be culturally competent in order to work with patients' belief systems, family support systems, and alternate health care providers, such as the Hispanic/Latino curandero, and thereby to provide truly adequate health care to Latino patients. Recommendations for the special needs of Hispanic/Latino underserved patients are as follows.

1. Hispanic/Latino communities require immediate and sustained financial and technical assistance to develop and expand clinics and hospitals within our communities that are sufficiently prepared to meet our health care needs .
2. The plan must have federal mechanisms to provide incentives (perhaps tied to reimbursement) for culturally competent treatment/providers in underserved areas.
3. In order to create equal opportunity for Hispanics/Latinos in the use of health services, a health reform plan must prohibit race and national origin discrimination at the National Health Board, alliance, health plan, and provider levels. A health reform plan must also provide for federal civil rights monitoring, data collection, and enforcement of remedies to ensure that any possible discrimination is detected and eliminated.
4. Hispanic health care providers need increased access to information about trends in national and local health care and about survival in a managed care environment. Education of community health care providers would lead to increased involvement of Hispanic nurses in local health care systems.
5. Grants to community/migrant health centers should be expanded. The number and magnitude of these grants are too low, given the problems with estimating the numbers of people served by these clinics.
6. Seed money is sometimes offered by the government to encourage health care providers in underserved areas to develop new plans. However, our providers will need long-term, low interest loans, not just seed money to exist and to serve in low-income areas.

7. All segments of the country must be involved in implementation and policy design, including Latino representation on the National Health Advisory Board and at all levels of the proposed system.

The Need for Hispanic Nurses:

Today, Hispanic/Latino nurses have not reached the expected representation based on our population. This is due to the paucity of opportunities for Hispanics to enter nursing and the need for more economic support, role models, and mentors for Hispanics in nursing schools not only during their education but also during the early stages of career development.

The Hispanic/Latino community needs to achieve equity in nursing. According to the 1990 census, the Hispanic population in the U.S. is 9 percent, however, Hispanic nurses make up 1.4 percent of nurses in the U.S. of whom .01 percent have doctoral degrees, 5 percent have master's degrees, 38.0 percent have associate degrees; 26.4 percent have bachelors degrees, and 29.9 percent have diploma degrees (National Sample Survey of Registered Nurses, 1992). Thus, with only about 45 doctorally prepared Hispanic/Latino nurses in the U.S., there is a dearth of Hispanic nurses educated to assume leadership positions in the delivery of health care to Hispanics. The health care reform plan must expand mechanisms to increase Hispanic/Latino nurses. Recommendations for the recruitment, retention, and career mobility of Hispanics in nursing are:

1. There should be coordination and annual monitoring of all federal Hispanic/Latino recruitment programs for the sciences and nursing from the DHHS Secretary Office.
2. Identify and secure equitable distribution of funds for recruitment, retention and career mobility of Hispanics/Latinos into nursing. Establish funding incentives targeting the entry and retention of Hispanics/Latinos in undergraduate and graduate nursing institutions.
3. Hispanic Centers of Excellence must be enhanced to include nurses.
4. There should be increased funds targeted at elementary and secondary education for math and science and mentorships in Hispanic communities.

5. Hispanic/Latino faculty development should target nursing faculty in four-year colleges and universities and in community-based clinics that are linked to nursing schools.
6. There should be partnerships with the private HMOs and Insurance Companies to raise the funds available for nursing education and recruitment programs - nationally.
7. Increase the participation of Hispanic/Latino nurses in decision-policy making level of educational, governmental, and health care agencies to ensure equitable representation. Increase the participation of Hispanic/Latino nurses as consultants, researchers, leaders, and appointment to boards committees, and task forces.
8. Certain communities need Hispanic/Latino nurses more than others. The workforce planning should be done at the state level, based on mandatory manpower planning.

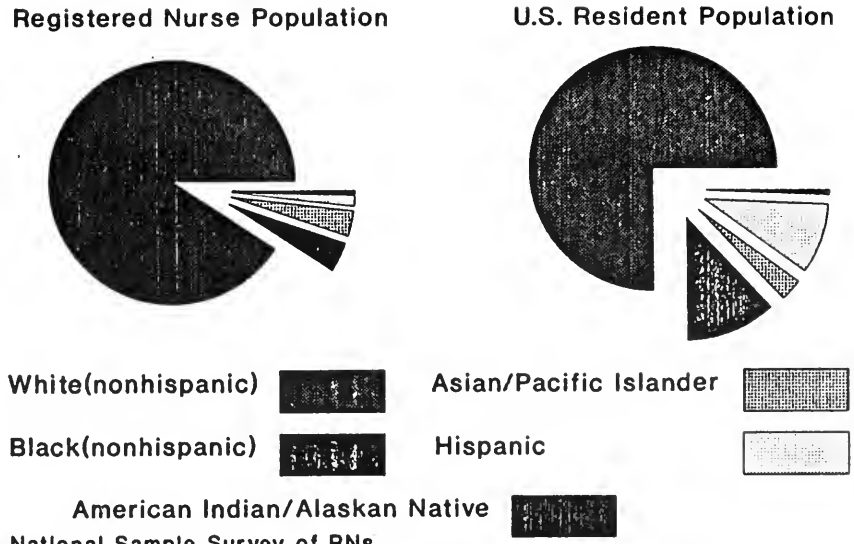
For additional information, please contact Sara Torres, President of the National Association of Hispanic Nurses at (704) 547-4659. Fax: (704) 547-3180.

DATA FROM

NATIONAL SAMPLE SURVEY OF REGISTERED NURSES
MARCH 1992

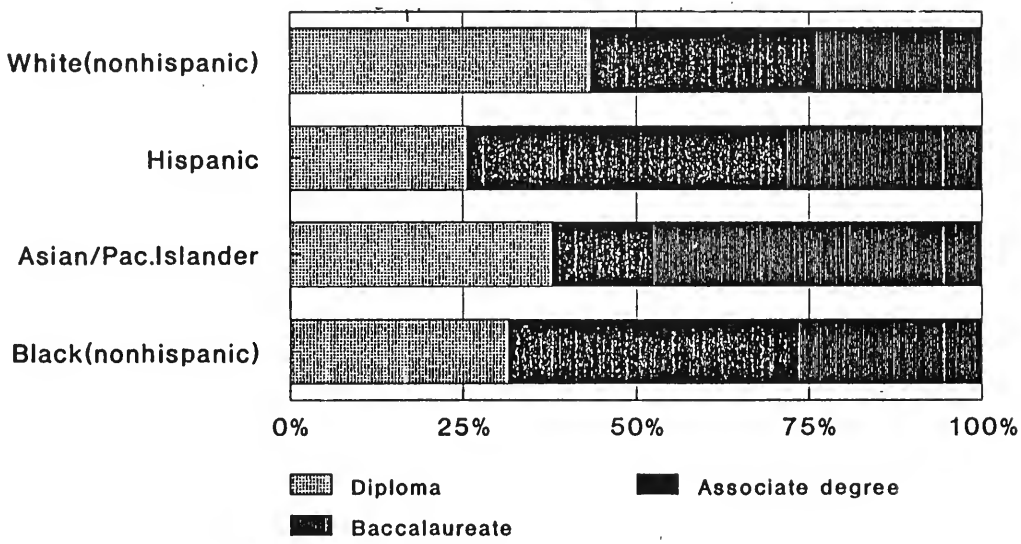
Division of Nursing
Bureau of Health Professions
Health Resources and Services Administration
Public Health Service
U.S. Department of Health and Human Services

DISTRIBUTION BY RACIAL/ETHNIC GROUP



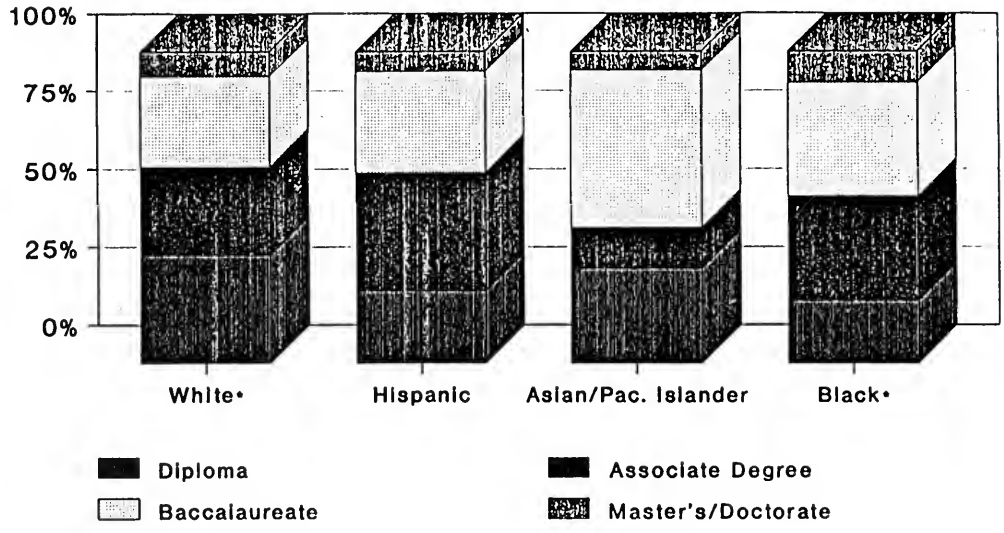
Sources: National Sample Survey of RNs, March 1992 and U.S Resident Population as of July 1, 1991.

DISTRIBUTION OF REGISTERED NURSES IN EACH RACIAL/ETHNIC GROUP BY BASIC NURSING EDUCATION PREPARATION,MARCH 1992



Source: National Sample Survey of R.N.s.

DISTRIBUTION OF REGISTERED NURSES IN EACH RACIAL/ETHNIC GROUP BY HIGHEST NURSING EDUCATION, MARCH 1992



•Nonhispanic.
Source: National Sample Survey of R.N.s.

Mr. PAYNE. Thank you very much. As you know, all of your complete testimony will be included in the record, and we keep the record open for additional questions for responses. So thank you very much. Mr. Van Noy.

Mr. NOY. I would like to thank Congressman Towns and the panel for having me here today. I am going to summarize what I have written, because several of the physicians have covered areas, including the area which I am very much concerned with, especially since my company, Consolidated Critical Care, is an ancillary care provider. We provide durable medical equipment in the State of Georgia, and I have several offices throughout the State of Georgia, and we depend wholly on these physicians, nursing services, and other medical institutions in the black community to be able to give us our business, and being that they are being whittled away, or at least their patient base is whittled away by managed care, of course it affects my business as well. But I will speak on areas that cover the ancillary side.

Our company, Consolidated Critical Care, is a JCHO-accredited firm. In fact, we are the only minority accredited medical—durable medical equipment provider and respiratory service provider in the State of Georgia. And as a result, we have not been able, even with the accreditation, to break into any of the majority hospitals, any of the majority nursing agencies, and it has only been through our minority counterparts that we have been able to survive. I do say survive, because many of my minority cohorts who are in business along with me are not surviving, as I am here today to hopefully emphasize as to why.

Racism in Georgia is alive and well. We still have our Confederate flag that we all basically are under, and as a result of chronyism, nepotism, bigotry, and people not understanding our culture, they have not opened their markets to us. However, our market is a target market. In Atlanta where we have a population better than 2 million, better than 55 percent of the population sits below I–20 in the minority communities. There are a total of 32 hospitals in Atlanta with only two sitting below I–20, and those two hospitals have not been included in any managed care consortiums or alliances or mergers, with the expressed intent that the populations below I–20 will become the target market for those hospitals above I–20.

The specialists that are now being brought into these particular programs, the hospitals that are being brought into these programs, are paying a high amount of money to join IPA's and medical alliances with the expressed intent of getting more covered lives from the minority community. In certain instances, hospitals on the north side of town are now busing Medicaid patients to have babies up in the north side of town, bypassing the minority hospital that had routinely delivered those babies in the past. As far as the ancillary care services in which I am involved in, the nursing companies are involved in, the physical therapists, the respiratory therapists, the IV infusion companies, most of which have depended on these minority companies, are now going out of business as a result of the fact that the contracts that are given to these managed care companies will not even send an application to a minority firm.

It is no longer called discrimination; it is called selective exclusion. And it is not only happening, of course, to the minority firms, but it is happening to the small majority firms, as well. I get deeply disturbed when I listen to President Clinton's speeches talking about how small business will benefit from managed care. There is nothing further from the truth than that statement right there. Managed care survives by giving contracts to one or two companies and then arranging for lower payment from that company.

In Atlanta, the buzzword is vertical integration. They are looking for a home care company that offers everything under one roof, which means that you have to have nursing, physical therapy, durable medical equipment, respiratory therapy, everything under one roof, and there is only one company that has that, and that company has all the managed care contracts in Atlanta. As a result, minorities are completely shut out.

I have watched my patient base drop by better than 40 percent in 1 year. We have watched our hospitals go from 50 percent private insurance-based to now down to less than 10 within 2 years. Although we are on the panels at the hospital to get managed care business from all of their different vendors, no one sends patients to us.

I have been fortunate enough to fight with the various majority home health companies in the Atlanta area where I have convinced them that having a minority joint venture will work for them as health care reform comes down the pike, and some of them have bought into it.

So now I am an ally of several of these companies, and with that, I have been awarded the first managed care contract given to a minority home health company in Georgia this past year, with several more now that are going to be given to me. However, that only happened as a result of Grady Hospital, the largest hospital in the State of Georgia, finally, with a change of administration, deciding to actually back up the minority participation rules that it has always had. It has always asked for 30 percent minority participation, but no one has ever enforced it. Up until a year-and-a-half ago, less than one-half of 1 percent of Grady Hospital's business was done by minorities. But when it did enforce it, I was able to use that as leverage. And those companies then allowed me to joint venture with them.

By the time national health care reform comes around, many of my cohorts will be out of business. So I am not here today to talk about national health care reform, because by the time you guys get it done, it will be all over with for us. However, what I am here to say is, a major key in helping minorities get the business that they deserve and need is to enforce some of the plans that you already have in place. All of these managed care companies are dependent wholly upon government contracts, statewide contracts, county contracts, all of them have minority participation rules in place, but nobody enforces them, and no one monitors them.

The minute that they know that it will affect them in their pocketbooks, or the minute that they know they stand a better chance

of beating out the other managed care company to get that contract by having minority participation, all of a sudden we will be in vogue.

I want to thank you for the opportunity to speak.

[The prepared statement of Mr. Van Noy follows:]

CONSOLIDATED CRITICAL CARE, INC.

1575 NORTHSIDE DRIVE
BUILDING 300 SUITE 330
ATLANTA, GEORGIA 30318

In anticipation of National health care reform, medical institutions, insurance carriers and health care providers are frantically forming networks and alliances in order to bundle services and provide regional coverage. It has created an environment of winners and losers. Instead of practicing medicine, providers find themselves discussing the latest merger or acquisition and how it affects them. No one wants to be the one left standing when the music stops.

One group particularly vulnerable during this period is the minority provider. Many were slow to realize that managed care was not a passing trend and did not get on board early. The rules have since changed. Enrollment in their plans has soared and now they dictate who is selected on their medical panels and who is rejected. They do not have to tell the provider why they weren't selected nor why they were dropped from the plan.

Managed care companies, as all businesses, are driven by the bottom of the line. They have target markets based on location, age, health status and income. This is why many minority providers, serving low income patients that have serious medical needs, are excluded. It is not necessarily the doctor that is being rejected, it is the patient. However, it is easier to drop the doctor hoping the patients go to the emergency room for service.

Although some patients in the minority community are unwanted, the community as a whole is looked upon as a undeserved market. Managed care is used as a vehicle to lure patients from one area of the city to another. In Atlanta, many of the health care panels consist of physicians on the north side of town. Physicians within the community are not selected. Without making an investment within the community, patients are now traveling 30 miles to see the doctor. Many have to travel by bus.

This is devastating to the minority provider at all levels; the hospital, the physician and all ancillary services. Ancillary services such as nursing agencies, physical therapists, respiratory therapists and durable medical equipment vendors are all wholly dependant upon physician and hospital referrals. The loss of our patient base undermines each ancillary company. It is particularly painful when the managed care company refuses to allow them to enroll in their plans.

The latest buzz word in ancillary services is "vertical integration" which means having access to all services under one roof. Instead of contracting with the different types of companies, find one and hold them responsible for the entire contract. The concept is fine, yet it is very expensive and none of the minority companies have the capital to produce one. This is especially true since our patient base has eroded. There is only one company in Atlanta that has this capacity. Largely through government grants, United Way monies and charitable donations they have developed the "one stop shop". Consequently, they get all the contracts. Managed care companies won't even send a minority company an application to apply.

Additionally, the state of Georgia is a certificate of need state (C.O.N). You are required to possess a C.O.N if you are going to process medicare claims. Although managed care contracts have little to do with medicare, nursing agencies are required to have a C.O.N in every county the managed care company services. In Atlanta most serve an 18 county area.

This is particularly disturbing because the state is not issuing any more C.O.N's in Atlanta. The original consulting fee to apply for a c.o.n was $7,000 - $10,000. However, the cost to buy one today is about $250,000 per county. Minority companies who were unable to afford to apply for one can not begin to purchase one let alone several. There are only two minority owned nursing agencies in Georgia that have C.O.N's. One company has one, and another has three. Since nursing care is the driving force behind home care, we have been shut out of the home care market by managed care.

Recently, I convinced a majority owned home care company of the advantages to joint venturing with a minority firm. They possessed the C.O.N's and I have a JCHO accredited respiratory care and durable medical equipment company. The alliance had resulted in the first managed car contract awarded a minority home care company in the southeast.

This joint venture was made possible because the largest hospital in the state of Georgia "Grady Memorial Hospital" strongly encouraged it. It was through their urging that we were able to make this happen. Grady Hospital created the right environment. It has been the incubator for many minority businesses in Atlanta. They have given us the opportunity to grow, with sizeable accounts and real direction. It is a program that works and it should be duplicated in other institutions. In order for minority companies to be able to compete in this market, the unfair restrictions will have to be erased and minority participation strongly encouraged. Grady Hospital has proved it can work.

The government has always set the goals for minority participation but these are not strongly encouraged or monitored.

I am disturbed that the President's health care policy does not address how minorities will participate in the delivery of health care. We need a workable plan that is detailed.

Under the present course, our communities will be devastated. The minority community already lacks a strong economic base. We need medical facilities within our community and jobs that will employ our people where they live. The dollars circulated in that community will create opportunities for service industries and retail stores. This is important because the two major issues facing the black community is crime and unemployment.

No longer can we as people stand by as policies and programs are being designed to make communities and us your field hands. We are only asking for the chance to create jobs and opportunities within our own communities. This will enable us to offer something to the children who we have lost to the street. I urge you to stop the political rhetoric, find a common ground and pass legislature that is fair and includes minority participation.

Mr. PAYNE. Thank you very much. And I think your remarks are very well taken. It took three times the amount of time, but it was so interesting that I dared not cut you off, that was for sure, and I think your points are certainly well taken.

The persons who are dealing with health care reform are aware of the practices that have gone on, and in the debate there have been attempted safeguards in many areas: medical colleges in their enrollment of minority students; a number of preferences given for a medical college, as I indicated, that has a record, if it is a majority college of having a high number of minority students. So we are looking at in the health care reform, we are concerned about participation on all levels. And I assure you that these areas will be looked into.

Let me ask a quick question to our nurses, and it is nice to see you back from the—I hope we didn't bring you back from your convention early. But I have a lot of respect for your organization of the National Black Nurses Association, and in New Jersey we have a very strong organization of the black nurses, and I had the privilege of getting the national award last year. So I will ask you the first question.

We are concerned about minorities in nursing. As a matter of fact, when I was young, many, many years ago, there were a larger number, it seemed to me, percentage of African-Americans in nursing. There seemed to have been a decline as the years moved on.

What can we do, in your opinion, and Ms. Torres if you would like to also answer, to ensure that minorities are not left behind in terms of advanced practice nurse training? Because what we are concerned about and are afraid of, that we won't have enough nurses with the graduate level training who will be prepared to become mid-level practitioners. So I wonder if you would like to respond.

Ms. TOMPKINS. Currently there are less than 5 percent of the nursing work force is African-American, and there has been some loss of numbers over the last few years. We, of course, are acutely concerned, too, and we spent a lot of time at our conference trying to prepare our nurses for where they need to be in the next several years. Advanced nursing practice of course is the key. And many of our nurses are prepared at the associate degree level, and therefore, are not prepared to take a major role in this advanced nursing practice era.

So without question, National Black Nurses Association supports some considerable educational resources from the Federal Government in order to support the nurses enrolling in programs for advanced nursing practice.

Now, what this means is, some redistribution of resources, fully funding title VIII so that we can get a larger number of nurses into the baccalaureate nursing program, moving from LVN programs and associate degree programs to baccalaureate programs. And of course once they finish those baccalaureate programs, to give them additional supports that they can go into advanced nursing practice, which—and certification programs that in most instances demand masters-prepared education in order to be a certified nurse, midwife. In order to be a pediatric nurse practitioner, a family nurse practitioner, graduate education is required.

As the physicians have said, one thing that certainly has been proven over the years is that African-American nurses remain in their homes in underserved poor areas. If you look at my home State or city, you might want to call it, of the District of Columbia, the nurses that are educated here at our city universities and colleges remain here, and they remain working in poor, underserved areas, unlike other majority students. So it is critical that these students get the support that they need to continue their education.

Because many of them start out without the education and the monetary support that they need to enter the university setting at the first level when they get ready to go to college. Many of them do take—go through the associate degree program or the LVN Program, which really puts them behind at the very start. So, I think some of the questions about mentoring and helping students at the elementary and secondary school level is very important. That is the time that they should begin preparing for careers in nursing.

The other thing about careers in nursing is that it aids the black community in terms of economic development. We are able, with the career ladder that is in nursing to move people from parts of the city where they cannot make a contribution as taxpaying citizens to enter nursing and become taxpaying head of households for both men and women in this profession.

Mr. PAYNE. Thank you.

Ms. TORRES. I agree with everything Ms. Tompkins has said. Anything I say is in my personal opinion; I am not prepared to speak on behalf of the nurses association.

But from my perspective I see the need in advanced education as well as at the college—the high school level, and the junior high school level, because a lot of times minorities don't even think about entering a profession because they think that they can't do it. They can't even envision themselves. They don't have role models. They don't know anyone who is a nurse. They don't have anyone who tells them you can be a nurse, you know, how to prepare to even get into a nursing program, get their science courses, get the preparations they need. So it needs to be attacked on all levels.

Mr. PAYNE. Thank you. Yes?

Ms. TOMPKINS. Another comment, to speak about role models. Thirty-plus years ago when I was a public health nurse, the District of Columbia had 300 public health nurses. Today the city has around eight public health nurses. And, I think, as we look at health care reform, one of the areas that we should look at not only for improved health care and health status in the minority community is to put resources back into community health nurses.

Health promotion, disease prevention, was really carried on the shoulders of public health nurses and we need those large core of educationally prepared nurses to be back in the communities, not only educating around health status, but also to serve as role models so that youth and other family members can see nurses in these various roles.

Mr. TOWNS. Do you know whether they still have nurses in the elementary and secondary schools in the District in each school on a full-time basis?

Ms. TOMPKINS. Yes, the District does. If you will recall, the District is under court mandate to have nursing—school health nurses in every school at least 20 hours per week, and there are full-time nurses in all secondary schools.

Mr. PAYNE. That is good.

Earlier the chairman talked about the fact that it is difficult sometimes for providers to show outright discrimination on the part of HMO's, as he said, due to the company's ability to drop provider contracts without justification. I don't know if you were here when he talked about an incident last April when the Sigma Health Care System of Kansas and Missouri announced the termination of more than 500 physicians in 9 major hospitals from its HMO plan. A disproportionate number of those who were terminated were minority providers. The only reason given, though, by Sigma for the termination was restructuring and realignment of their managed care system designed to improve service to clients, was their answer.

Let me just ask the nonmedical providers, that even though we have heard a criticism of the Sigma Health Care, what I recently quoted from the chairman; we also know that they were responsible for bringing a group of black physical therapists into the network in your State of Georgia, a nonphysician provider. Do you find that HMOs are willing to work with you in a creative fashion to ensure that there is diversity within their provider network?

Yes. What was that terminology you used before, selective——

Mr. NOY. Exclusion.

Mr. PAYNE. OK.

Mr. NOY. As I am also on the Sigma Health Plan, in fact, I have just been given the national Sigma Health Plan for the State of Georgia. And I think it comes as a result of the amount of flak that Sigma has received as a result of excluding minority physicians.

You see, from the angle of durable medical equipment and ancillary services, it doesn't cost them a dime, versus other types, such as the physician side. We are capped, we get x amount of dollars for every piece of equipment.

So, it didn't make a difference to them whether I was white, black, or blue, as long as I agreed to that certain cap for my medical equipment. It isn't like having a physician where he could have a sick patient base and that patient base continued to go to the hospital. So when it comes to durable medical equipment, it is a very easy program for them to include minorities, and the rest of the managed care companies, they just choose not to.

Mr. KING. I would like to add something to that, and that is that in my area, they are looking for a similar kind of a program where you have the one-stop shop, as they call it. I don't know many minority business owners that can provide that kind of thing in a large region. We don't have that access to capital. So there is really no incentive for them built into an HMO program, as it is now, to include you in their contract.

Mr. PAYNE. Would the attempt to bring together individual minorities who are specialists, to attempt at that vertical integration you talked about before?

Mr. NOY. I leave here to go to New York where I am buying one of the majority nursing agencies, and that majority nursing agency

realized that when it comes to the tears of majority agencies that they are competing against, they are on the bottom. And the top three are going to be the ones getting all of the contracts.

So I explained to them, either you sit at the bottom at number eight and you get nothing, just like me, or you allow me to purchase you and go in as a minority contractor for joint ventures, and I am not competing with those top tiers. I don't compete with anyone.

In the State of Georgia, we are a CON State. And as a CON State, you can only get Medicare claims processed if you have that CON. Unfortunately, there are only two black nursing agencies that have CON's in the State of Georgia, unlike 100 other companies that do have them. And being able to purchase the company that has CON's, we now are going to be able to have that vertical integration. That is something that I suggest for other parts of the country, as well.

Mr. KING. I would like to say one last thing on that. As a member of a National Association of Medical Equipment Suppliers, a number of our members are small businesses, and I would like to add again, there needs to be some structure, I believe, with HMO's to bring those community businesses into those contracts. Because if not, what Mr. Van Noy is alluding to, is in this country there may be four or five of those kind of large providers within the next 5 to 10 couple of years.

Mr. PAYNE. All right. Let me also ask, how did your problems in dealing with a managed care network differ from that of physicians? Is it basically the same, or do you find the same problems?

Mr. NOY. Well, I will answer. I think our problems are quite a bit different than theirs. Unlike the physicians' business where it has always been that the key has been quality of care, patient access, things of that sort, durable medical equipment is considered a straight-out business. Although we do provide respiratory care and other services, it is a bottom line numbers business: Can you perform this business at a specific price?

And when you are asked to provide business in a capitated arena where I am receiving somewhere in the neighborhood of 13 cents per person, although my average cost of equipment is better than $225 per equipment, and you are giving somewhere in the neighborhood of a half million lives to cover, quite quickly you can do the math on that and realize you can be upside down very quickly.

In an integrated service arena, as they call it, where you have nursing, medical equipment, physical therapy, they figure that what money that you make in overages from those other specialty areas you could use if you were upside down in the durable medical equipment side, where you don't have that if you are a stand-alone durable medical equipment provider. And the kind of profits that you make do not by any means cover you being able to have 500,000 lives covered for 13 cents apiece.

So our problems are unique, they are different, and quite frankly, being that we do not have the lobby that the physicians, the nurses, even the physical therapists or respiratory therapists have. We are really out there on our own.

Mr. PAYNE. Let me just ask this, sort of following up on that. Do you feel, is it that bleak for small business people in the health

care field? And what can we do in your opinion to help prepare minorities in the various fields to effectively compete in this new system?

Mr. NOY. Well, first of all, I sincerely believe in home health. It is going the way of the sole proprietor and the pharmacies. With Wal-Mart, Drug Emporium, Treasury Drugs all moving into the area with very low prices, the small vendor is going the way of the dinosaur.

The only way that we as a group, especially the minority provider, can continue to exist is by some government intervention, whether it is on the local level, State level, Federal level, and that is to require services that reflect the community. Why in the world could Atlanta, home of civil rights, allow managed care to come in and wipe out all of our businesses? And it is.

As we sit here and talk today, I guarantee you there is somebody ready to close. So what it comes down to is the State and the cities have to go ahead and strongly encourage—they can't mandate—they have to strongly encourage minority participation right away, just in the percentages that you already have. The State of Georgia has a percentage or a goal of 10 percent minority inclusion on all contracts, but what they offer is like a $300 deduction off of your—off of the majority company's State taxes if they do it. Who cares?

When the contracts are so doggone large, why in the world enforce the 10 percent? In the State of Georgia, 30 percent of the contract—I mean 30 percent of the population in the State of Georgia is black. But in every major city, and I mean every one of them, it is over 50 percent black, and none of those companies have contracts with any of the major hospitals. So something needs to happen. And believe me, if we can be wiped out in Atlanta, minorities will be wiped out in every other place in this country.

Mr. KING. I would like to speak to that in California. I was recently approached by one of the health maintenance group of hospitals, because my company has such a good record for providing respiratory care and home medical equipment in the home. We had great outcomes with our patients. We had even written grants that the Chairman of the National Sleep Commission said could, if they were operationalized, he believed they could take about $24 to $30 million off the national health care budget. But those companies approached me to ask me to train their respiratory therapists to do that kind of thing. I don't have the business from them to do it.

Mr. PAYNE. Yes?

Ms. TOMPKINS. As far as nurses are concerned, one of the things that we are supporting is direct reimbursement of nurses. Some State managed care programs do not—only pay physicians directly as primary care providers, and pay advanced practice nurses through those physicians, which really increase costs overall. What we are supporting as a part of the legislation is direct reimbursement, directly to nurses and not through conglomerates and through HMO's.

I think the other point is, if we focus on quality of care as the important measure for health care reform, I think we will include all of these various points that we are raising: cultural competency, minority involvement, et cetera, at various levels; patient satisfaction. All of these things are taken into consideration when there is

monitoring and evaluation, so that you look at who are the providers that are involved in the health care reform system.

Mr. PAYNE. Well, as you can hear, those bells, I have a few minutes to get to vote. But let me thank the panel very much. It has been very enlightening, and I think this has been extremely helpful for our committee as we look at this reform, and your suggestions will certainly be noted, and we will see if we can accommodate some of the problems that you talk about. Perhaps we will be able to eliminate the possibility for them to come up.

So once again, thank you all very much.

Ms. TOMPKINS. Thank you.

Mr. PAYNE. This meeting stands adjourned.

[Whereupon, at 1:30 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

Community Home Medical

P.O. Box 3455, Grass Valley, CA 95945
(916) 477-5141 • 1-800-698-9847

August 4,1994

Hon. Edolphus Towns
Chairman
Subcommittee on Human Resources
and Intergovernmental Affairs
Suite 2332
Rayburn House Office Building
Washington, D.C. 2051?-3210

Dear Congressman Towns,

I was contacted via E. Whitney Tannen of the National Association Of Medical Equipment Services (NAMES)to participate as a witness at your hearing regarding "The Impact of Health Care Reform on Minority Providers" and by the Chairman on July 29, 1994.

I have been a provider with majority ownership of Community Home Medical Inc. (CHM) for over five and years. CHM is accredited by the Joint Commission On Accreditation Of Healthcare Organizations (708) 916-5600 for Clinical Respiratory Homecare and Home Medical Equipment Management. My background is as a respiratory care practitioner. I have worked in teaching hospitals, community hospitals, and medical centers over the last twenty years. Part of that experience was as Technical director and Chief Respiratory Therapist at Children's Hospital at Stanford in Palo Alto, Ca.

Your first question addresses my concerns regarding the proposed health care reform legislation and my opinion as to how they will effect minority providers.

My concern as a minority supplier is who will be contacted to bid on Medicare and HMO contracts. Second, what qualifications will be required of those bidding to fill the needs of the patients (Medicare or HMO beneficiaries) with oxygen systems, respiratory therapy, durable medical, and mobility equipment.

In a competitive low bid winner-take-all scenario. I believe that minority and small providers will not be on an equal footing to bid. I believe this method will also cause the patients (Medicare and HMO beneficiaries) to have tremendous re-infection rates, higher hospitalization rates and poor compliance with most plans of treatment that their physician has prescribed for them to use in the home. (Please see attached #1 & #2)

I was contacted by mail from a large Northern California HMO in 1991 by their "minority outreach program". They requested all sorts of information, listing of board of directors, licensing, proof of minority status, recent profit and loss statements and even requested a picture I.D. to substantiate minority status. Although I spoke with them by phone to discuss my company and

spent much time to provide all their requested information when it came time to bid in 1994 I was not even contacted to contacted to participate. By the time I called the HMO they had awarded the contracts to one national company and one regional company. Neither the regional provider nor the national provider of have the accreditation level of CHM

Managed care plans today often contract with the largest lowest bidder they can find without regard to quality or services. For example, a recent HMO merger caused a forced change of services for an elderly woman who had been a client of Community Home Medical (CHM) for about three years. She sent a copy of a letter to her HMO in 1993 and again to me July 1994 voicing her concerns about these changes in health care. (see attached #3 & #4). She had initially endured a number of hospitalizations for pneumonia and fatique. As a result of "sleep studies" the physician ordered a treatment plan in which CHM to gave her oxygen, ventilated the patient and taught her about her illness in order for her to remain at home. This treatment has been effective for over two years without hospitalization. This client is stable and productive with her family and community.

Her new HMO carrier has changed her provider of HME service eliminating her right to choose. Although she has stated by phone and letter that she wishes to stay with CHM, she is afraid she will lose her only health coverage if she fights too hard for her preference.

A final concern in this area is the relaxation of anti-trust regulations. I have experienced a situation in a community in Northern California where a corporation owns the only two hospitals in a community. The corporation also owns interest in a medical equipment dealership (with no accreditation). The referrals never come to my company for Medicare covered or private insurance patients. However CHM has received almost all their Medi-Cal baby referrals who need apnea monitoring and involved care for a small monthly rental fee from the state. CHM has been available 24 hrs./day 7 days a week I have done home visits in the middle of the night to re-instruct more than one distressed mother when an alarm went off repeatedly and the mother could not remedy the situation. The Medicaid program does not reimburse for those visits or reinforcing and teaching parents how to do CPR (in English, Spanish and even Hmong). I understand the anti-trust regulations are being relaxed under health care reform, I think the effect on small and minority owned business and patients in this case is apparent.

Your second question addresses What protections for minority providers, in your opinion should be included in the health reform bill?

One remedy would be to establish a due process for bidding on healthcare contracts. This involves public notice, and an open bidding process which is based on the ability to provide

accredited equipment and/or care to insure patient safety. The standards should be included as pre-requisites for bidding eligibility. In this manner all qualified providers may bid and hopefully more than single bid winners will be awarded as that brings competition to the table.

Another protection for small and minority businesses would be to expedite payment from Medicare or at least require carriers to meet the payment deadlines required by congressional law. (See attached #5) CHM has claims held by Medicare for greater than 30 days in excess of $138,000 dollars and greater than 60 days in excess of $100,000. That is just under 10% of CHM gross annual revenue ! This impacts tremendously a small or minority owned business. Banks look at U.S. Government receivables as discounted because they take so long to pay. In fact Medicare carriers may get increased administrative cost incentives to reprocess claims. I believe it would be helpful and cost effective to make the Medicare contracts public information so that the Medicare carriers could be held to a standard for fraud and abuse along with health care providers.

Your third request for response regarded;personal encounters with discriminatory practices when dealing with health maintenance organizations or any health-care related organizations.

Last September CHM ask Robert Wren Of HCFA as a result of our intimate contact with our oxygen patients in their home to re-interpret CIM 60 regarding Medicare oxygen payment for terminally ill patients in their home. Both Mr Wren and Dr. Zone, a Medicare Medical director agreed with our companies position. This kind of reform is now saving a lot of Medicare expense in unecessary hospital admission and emergency room fees(see attached #2 & #6).

Now I find a similar situation in terms of discriminatory practice where National corporations who own hospitals may charge Medicare part A for their respiratory therapists to give therapy to skilled nursing facility patients not in or attached to their hospital. No accreditation or specialized knowledge of respiratory equipment outside the acute hospital is required.

A significant inequity which could be rectified by a simple regulation adjustment regards the payment by Medicare for respiratory care in a skilled nursing facility. Under current regulation (see attached #7) a hospital can hire out their Respiratory Care Practitioners to do therapy and be paid part A Medicare in a skilled nursing home outside the hospital. This occurs even though those therapists or the hospital have no accreditation in clinical respiratory care outside the acute care setting. On the other hand, CHM as a JCAHO accredited entity for clinical respiratory care outside the acute setting can not charge Medicare for therapist treatments in a skilled nursing facility! The patient may have been a patient of CHM's, be treated with CHM gases and the physician may prescribe the respiratory therapy treatment in the skilled nursing facility. All this at less cost to Medicare part A than in the hospital.

This makes equal opportunity impossible and restraint of trade a reality weighted in favor of providers other than minorities and small businesses.

Your fourth response request was for; Adjustments that you had to make due to increased efforts in your area to form managed care organizations.

I have had to market harder than previously. CHM used to grow by just physician referral and word of mouth based on excellent patient care and outcomes. Now physicians have become part of practice groups purchased by HMO's or affiliated with large managed care networks. The individual physicians may not know who their contracted providers are as mergers and aquisitions occur under managed care. CHM has had physicians order our service to be told by the HMO -"they are not your contracted providers". It is not a choice unless the patient is willing to self-pay.

As noted recently and stated best in the July-August 1994 Harvard Business Review,"The United States can achieve universal access and lower costs with out sacrificing quality, but only by allowing competition to work ay all levels of the health care system." I am asking you to give me the chance to compete.

Sincerely,

Robert W. King

Robert W. King RCP
Member National Association Of Equipment Services
President/CEO
Community Home Medical Inc.

WALLY HERGER
2d DISTRICT, CALIFORNIA

PLEASE REPLY TO

☐ WASHINGTON OFFICE:
1108 LONGWORTH HOUSE OFFICE BUILDING
(202) 225-3076

DISTRICT OFFICES:
☐ 55 INDEPENDENCE CIRCLE, SUITE 104
CHICO, CA 95928
(916) 893-8388
☐ 2400 WASHINGTON AVE., SUITE 410
REDDING, CA 96001
(916) 241-8888
☐ 981 LIVE OAK BLVD., SUITE 11
YUBA CITY, CA 95991
(916) 673-1917

COMMITTEE ON AGRICULTURE

COMMITTEE ON MERCHANT MARINE AND FISHERIES

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

Congress of the United States
House of Representatives
Washington, DC 20515-0502

October 29, 1992

William Toby
Acting Administrator
Health Care Financing Administration
200 Independence Avenue
Washington, D.C. 20201

Dear William:

As you are well aware, the upwardly spiralling cost of health care is of grave concern to both the Congress and the Administration. While we surely need to reign in costs, I am concerned about a HCFA cost-cutting proposal which I fear may actually increase federal expenditures on health care.

I recently visited the offices of Community Home Medical, based in Nevada County, and learned first-hand how crucial it is to have high, professional standards for "in-home" care. It is a demonstrable fact that, if correctly administered, oxygen therapy can prevent costly hospital stays. But the effective use of this therapy requires far more than simply dropping off an oxygen tank along with some cursory instructions.

In the attached letter and related documentation provided by Bob King, President of Community Home Medical, the human and financial costs associated with inadequate standards for oxygen delivery are outlined for your review. I would appreciate your careful review of this material.

Clearly, we must bring medical costs under control. However, we must also ensure that we do not make a short-term cost reduction which will result in long-term cost increases. I look forward to your assessment of the issues raised by Mr. King.

Sincerely,

COPY

WALLY HERGER
Member of Congress

WH/gg

A RATIONAL APPROACH

REVAMPING REGULATORY POLICIES FOR HOME OXYGEN—RATHER THAN INSTITUTING COMPETITIVE BIDDING—WILL GO A LONG WAY IN REDUCING HEALTH CARE EXPENDITURES.

■

BY ROBERT KING, RCP

"I would unite with anybody to do right and with nobody to do wrong."
—Frederick Douglass, 1855

Robert King, RCP

GERRY MCINTYRE

At this time, everyone is concerned with reducing the high costs of health care. There are several ways the HME service industry can help lower costs. It is apparent that price cutting is the order of the day. Competitive bidding, particularly for home oxygen, is frequently touted as the solution for reducing costs. I take issue with this in regard to what is included in a competitive bid. Does it include appropriate services and clinical care, or strictly delivery of equipment and/or oxygen and the phone number of an answering machine for client questions?

Federal and state regulatory agencies have instituted policies and procedures that have made intrusive cuts in HME service business profitability. For example, regulatory requirements have resulted in unpaid physician time for the completion of certificates of medical necessity and time lags in payments to HME providers. More important, though, are situations in which the HME services client is denied Medicare or insurance benefits. In these cases, clients experience ineffective health care outcomes, resulting in taxpayers and providers paying more unnecessary dollars.

Unnecessary dollars are often spent for hospice clients in areas where there is no Medicare-certified hospice. Referring physicians often order oxygen for terminally ill clients who become hypoxemic (low blood-oxygen level). However, hypoxemia often occurs at night or on the weekend, when it is not possible to obtain the testing required by the Health Care Financing Administration (HCFA) for Medicare beneficiaries to receive oxygen therapy. The ability to self-pay for this therapy is impossible for some clients.

Under HCFA mandate, testing with oximetry or arterial blood gas must be used to determine whether the patient is eligible for the Medicare Part B benefit. HCFA also requires that either test be administered by a doctor or accredited laboratory provider or in the hospital. Thus, a terminally ill patient who has chosen to stay at home and becomes hypoxemic must be admitted to the hospital—often at great expense.

I suggest that HCFA permit tests to be performed in the home. Tests are as simple and inexpensive as having a doctor's order to test the patient, an accurate oximetry device, and a registered nurse or respiratory therapist who can graphically record and report the result to the ordering physician. The report could be signed by the tester and the physician.

HCFA was approached about this issue during a recent National Association of Medical Equipment Services meeting in Washington, DC. Subsequently, Rep Wally Herger (R-Calif) contacted HCFA with the support of numerous letters from physicians and hospice providers requesting that this rule be reinterpreted. Revision of this policy would result in cost savings for taxpayers, HME providers, and clients.

HCFA, case managers, insurance groups, and HMOs do not have a lengthy history in the HME services field. They need information and case study outcomes to understand the service costs associated with responsible HME practices. We must document patient outcomes while decreasing hospital readmissions, emergency room visits, institutional ventilator care costs, and cost for hospitalization at the end of terminal illnesses.

Without HME service providers and manufacturers collaborating to gather and provide this information, very temporary, decreased health equipment costs are and will be a function of "service-deleted or loss-lead" competitive bidding. This will have little or no long-term effect on decreasing health care costs. Instead, this approach will limit the number of providers and decrease competition in the HME services environment.

As HME service providers, we must know and market the true cost of HME services and home care. We must try to change regulations that impede cost-effective, informed client care. There is incredible opportunity for home care and HME service providers and manufacturers to help the United States come home to great health care outcomes. □

Robert King, RCP, is president/chief executive officer of Community Home Medical, Inc, Grass Valley, Calif.

[redacted]

RECEIVED SEP 2 4 1993

Sept. 23, 1993

[redacted] - Senior Security
[redacted]

RE: Your letter of Sept. 13
To [redacted]

APPEAL FOR DENIAL OF COVERAGE, [redacted]

Gentlemen:

I have been on oxygen concentrator, C-Pap, and E-Tanks for more than 2 years now, and I do not understand your decision to dis-allow this claim.

When we lived in Grass Valley, my primary care physician was Dr. Stuart Campbell, with Dr. Lockhart as pulmonary specialist.

My breathing tests were ordered by Dr. Lockhart of Grass Valley, and sent to Stanford hospital for evaluation. I was put on oxygen and my condition has improved considerably. Community Home Medical of Grass Valley has been my supplyer all this time, and are still caring for me.

Aug. 7 of last year, we moved from Grass Valley to Elverta to be near our children. This necessitated a change of Doctors, so I chose Dr. Barbara Wilson, as primary care physician, and Dr. Lischner of 729 Sunrise, Ste. 603, Roseville as pulmonary specialist.

On June 1st, we joined [redacted], so we had to change doctors again. We chose Dr.Shipley, but stayed with Dr.mLischner. Now Dr. Shipley has joined the [redacted] group, so they tell me I may have to change my pulmonary doctor. I don't like all these changes - they cause too much confusion, but there is not much I can do about it.

To summarize: I have been on oxygen continuously for more than 2 years, serviced by Community Home Medical of Grass Valley, and under the supervision of Dr. Lockhart of Grass Valley, and Dr. Lischner of Roseville, and approved by Medicare - - - So what is the problem?

Sincerely,

[redacted]

Copy-
Commun. Home Med.
Dr. Lischner
Dr. Shipley

[redacted]

July 26, 1994

TO WHOM IT MAY CONCERN:

I have sleep apnea. Community Home Medical had done several sleep studies on me, beginning in Jan. 1991, when we lived in Grass Valley, CA.

They have provided an oxygen concentrator and Bi-pap for my use since Jan. 1991, even after we moved to the Sacramento area, in Aug. 1992.

They have been very efficient and faithful, calling regularly each month to check the equipment, and monitor my progress and medical status.

I have been completely satisfied with their service and have no desire to change providers.

Sincerely,

Verla [redacted]

attachment GAO Report #5

coinsurance. There is no cap on out-of-pocket expenses for beneficiaries under Part B.

In accordance with title XVIII of the Social Security Act, as amended, HCFA contracts with 34 private insurance carriers to process and issue benefit payment on claims submitted under Part B coverage. Carriers are required to process claims in a timely, efficient, effective, and accurate manner. During fiscal year 1992, carriers processed about 550 million Part B claims submitted by nearly 900,000 physicians and suppliers. HCFA policy requires that carriers must approve or deny 95 percent of "clean" claims--that is, claims that do not require additional documentation--within 30 calendar days.[1] In addition, HCFA regulations require that 95 percent of all claims (clean plus all other kinds) must be approved or denied within 60 calendar days.

Carriers are required by regulation to pay only for services that are covered, and to reject or adjust the claim if they determine that the services were "not medically necessary"; in 1992, approximately 8 percent of claims were denied for this reason.[2]

[1]These figures may be further broken down as follows: (1) 95 percent of electronically submitted claims from participating physicians must be approved or denied within 15 to 17 days, (2) 95 percent of electronically submitted claims from nonparticipating physicians must be approved or denied within 15 to 24 days, (3) 95 percent of all clean paper claims must be approved or denied within 27 to 30 days.

[2]In fiscal year 1992, carriers denied 116 million Part B claims in whole or part (21 percent of all claims processed) for a total of $16 billion (which represented 18 percent of all billed charges). The percentage distribution of dollar amount denied by reason was as follows: duplicate claim (27 percent), service not

From GAO/PEMD-93-27 #5 August 1993 Medicare Part B Reliability of Claims Processing Across Carriers

Connecticut General Life Insurance Company
a CIGNA company

Medicare Administration
P.O. Box 690
Nashville, TN 37202

CIGNA

March 8, 1994

Mr. Dave Meurer
Office of Congressman Wally Herger
58 Independence Circle, Suite 104
Chico, California 95026

Dear Mr. Meurer:

I have reviewed the HCFA and Community Home Medical documentation as well as my original response.

The criteria for the home setting is the same as for a hospice. As long as the physician assumes and fulfills a supervisory role, the nurse or technician may perform the oximetry testing. When the individual performing the testing is an employee of a supplier or an organization under financial contract with the supplier, the test would not be acceptable. I interpret Mr. King's letter as stating that he is an independent respiratory contractor as well as be licensed to provide these services.

If there are any further questions on this matter, please contact me again.

Sincerely,

Robert M. Zone, M.D.
Medical Director
Region D DMERC

Part A Respiratory Therapy #7
Payment

necessary to permit or facilitate the patient's release from the facility. [MIM § 3133.6.]

Supplies, appliances, and equipment furnished to a patient for use only outside the facility would not, in general, be covered as extended care services. However, a temporary or disposable item, such as a sterile dressing, provided to a patient which is medically necessary to permit or facilitate his departure from the facility and is required until such time as he can obtain a continuing supply would be covered as an extended care service. [MIM § 3133.6.]

[¶ 1342] Other Diagnostic and Therapeutic Items or Services

Extended care services also include other diagnostic and therapeutic services provided by a hospital with which the facility has an agreement for the transfer of patients and the exchange of records, or by a hospital that has a swing-bed approval. While a skilled nursing facility is permitted to secure diagnostic and therapeutic services for its inpatients from the transfer hospital, the hospital must have the capacity to provide the services directly. If the transfer hospital does not have the capacity to provide the services directly, but provides them through an arrangement with an outside source, these services would not constitute covered extended care services. [MIM § 3133.8.]

Other services which are necessary to the health of the facility's patients are also covered if those services are generally provided by skilled nursing facilities. The medical and other health services listed in ¶ 1350 are generally provided by skilled nursing facilities and are therefore covered extended care services. However, items or services that would not be included as inpatient hospital services, if furnished to an inpatient of a hospital, are also excluded from extended care coverage. For instance, the provision of personal laundry services by SNFs is not a covered service under Medicare, since it would not be covered if provided to an inpatient of an acute care hospital.

The use of an operating room and any special equipment, supplies, or services that would be associated with an operating room would not constitute covered extended care services, except when furnished to the skilled nursing facility by a hospital with which the skilled nursing facility has a transfer agreement, since operating rooms are not generally maintained by skilled nursing facilities. However, supplies and nursing services connected with minor surgery performed in a skilled nursing facility that does not require the use of an operating room or any special equipment or supplies associated with such a room would be covered extended care services and reimbursed as part of the cost of routine services. [MIM § 3133.9.]

Respiratory therapy services furnished in the skilled nursing facility setting are covered if furnished to the inpatients of a skilled nursing facility by a transfer hospital or by a nurse on the staff of the SNF. [MIM § 3101.10.C.] For a definition of "respiratory therapy" and the kinds of services covered as respiratory therapy, see ¶ 1231.74.

The coverage of other diagnostic or therapeutic items furnished to inpatients by a hospital is discussed at ¶ 1231.

Concerning transfer agreements between skilled nursing facilities and hospitals, see ¶ 12,400 in the "MEDICARE AGREEMENTS" division.

[¶ 1346] Interns and Residents-in-Training

The medical services of an intern or resident-in-training under an approved teaching program of a hospital are covered extended care services under Part A if the intern or resident is in a participating hospital with which the SNF has in effect an agreement for the transfer of patients and exchange of medical records, or in a hospital that has a swing-bed approval. As to the meaning of an "approved teaching program," see ¶ 1235. [MIM § 3133.7.]

Statement by Maurice C. Clifford, M.D.

Former Commissioner of Public Health, City of Philadelphia
President Emeritus, The Medical College of Pennsylvania

To assure equity, health care reform legislation must contain language that specifically addresses the issue of unfair discrimination.

The legislation should require that:

> *"Payers and their agents may exclude from provider panels only practitioners who fail to meet state licensure requirements and standards of professional performance established by a relevant peer group."*

A footnote should define "relevant peer group" as professionals whose billings are comparable as to diagnosis related groups.

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